Harris Chiropractic Clinic

History Involving Accident or Trauma

Patient's Name: _____ Today's Date:_____

Sex: M/F Date of Birth:_____ SSN# (just last 4 digits): _____

Address:_____ Apt/Unit#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ Spouse's Name: _____ Phone: _____

Emergency Contact: _____ Phone:_____

Will we be filing Insurance for you? Yes No If yes, Name of Insurance: _____

Insured's Name: _____ Insured's DOB: _____ Relationship: _____

Address (if different from patients): _____

Patient's Occupation: _____

Employed by: _____ Work Phone: _____

Student Status: Full-time _____ Part-time _____ Name of school: _____

Patient's Name:

History of the Accident or Injury

Date of Accident or Injury: _____

Please describe how the accident or injury occurred on the following lines:

_____

_____

_____

If this was a motor vehicle accident, what was the year, make and model of the vehicle you were in at the time of the accident? Year: _____ Make: _____ Model: _____

What type of vehicle hit you? (Car, truck, van)? _____

What was YOUR position in the vehicle at the time of the accident? ___Driver ___Front Passenger

___Behind the Driver (Left Rear) ___Behind the Front Passenger (Right Rear)

___Other (Please Describe): _____

At the time of the accident were you wearing a seat belt? Yes No

Does the vehicle have air bags? Yes No

If yes, did the airbags deploy? Yes No

Where was your vehicle struck? ___Front ___Back ___Lt. Side ___Rt. Side ___"T-Boned"

Did your car strike another vehicle, pole, ditch, or other object **after the initial impact**? Yes No

If yes, please explain: _____

_____

Did you strike any objects or parts of the car during the accident? Yes No

If yes, please explain: _____

_____

Did you lose consciousness after the accident? Yes No If yes, How long? _____

Were you dazed or confused? Memory problems? Yes No If yes, how long? _____

Patient's Name:

Injuries/Symptoms IMMEDIATELY after the accident: _____

_____

Any changes to your symptoms later that day, the following day or week? _____

_____

Please describe your major problem or complaint today: _____

_____

Did you receive emergency treatment in a Hospital Emergency room? Yes No

How did you get to the Emergency room?

_____Ambulance _____Private Car _____Other

Name of Hospital: _____

Have you seen any other health care provider before coming here? Yes (Name:_____) No

Have you had any previous TRAUMAS, ACCIDENTS OR FALLS which maybe causing or contributing to the above problems? Yes No If yes, when? _____

If yes, please explain: _____

_____

SINCE THE ABOVE ACCIDENT have you had any accidents or falls which maybe contributing to your Condition Yes No If yes, when? (Month and Year) _____

If yes, please explain: _____

_____

What have you done at HOME to treat these problems? _____

_____

Does anything make the pain worse? Yes No

If yes, please describe: _____

Are your injuries interfering with sleep? Yes No If yes, how long? _____

Have you lost any time from work as a result of this accident? Yes No

If yes, how many days? _____

Do you have any WORK RESTRICTIONS? Yes No

If yes, please specify: _____

_____

Please describe your PRIMARY JOB DUTIES at work: _____

_____

Have your injuries caused any restrictions or difficulties with your usual daily activities? Yes No

If yes, please specify: _____

_____

Patient's Name:

Please indicate the **FREQUENCY** of pain as follows:

(C) Constant (75%-100% of the time) **(F)** Frequent (50%-75% of the time)

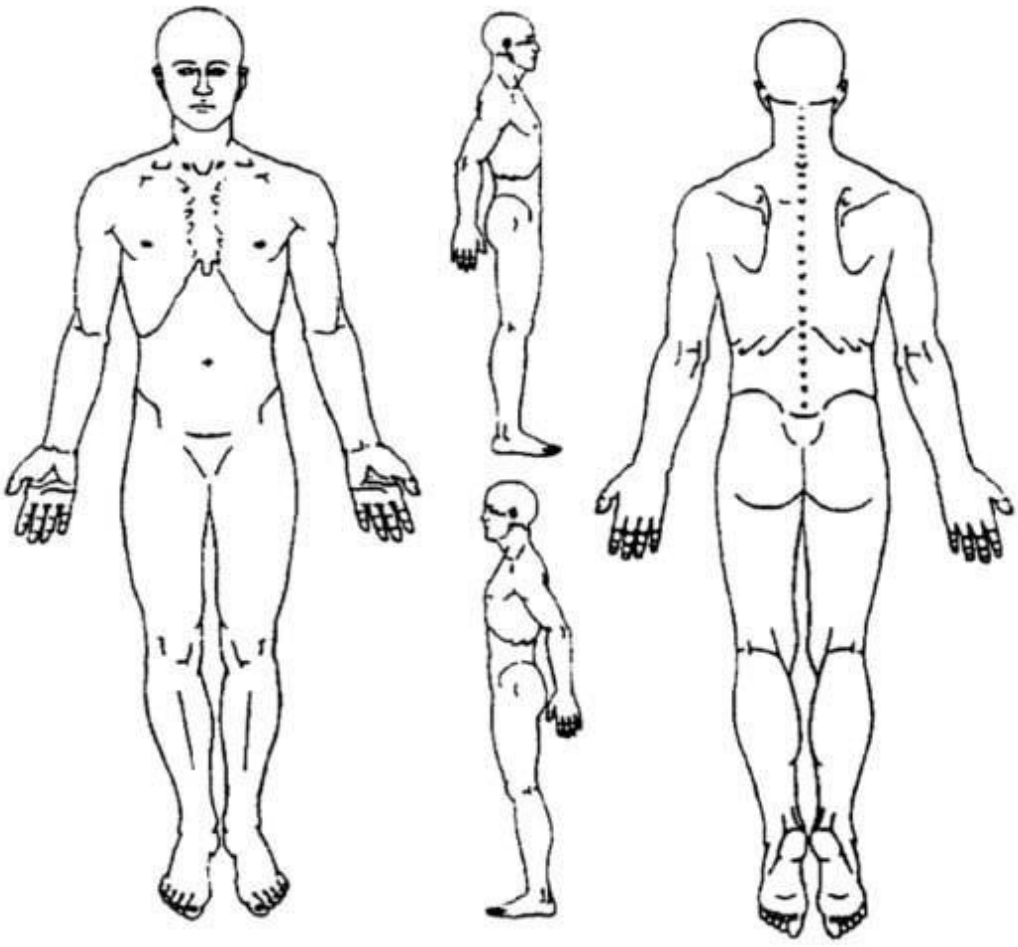
(O) Occasional (25%-50% of the time) **(I)** Intermittent (0%-25% of the time)

Please indicate the **QUALITY** of pain or discomfort by marking with a:

(**S**)Sharp (**D**)Dull (**N**)Numbness (**T**)Tingling

Please indicate the **INTENSITY** of pain as follows:

(on a scale of '**1**' to '**10**', with 10 being the worst) for each area:



MEDICAL HISTORY INFORMATION SHEET

NAME: _____ **AGE:**_____ **TODAY'S DATE:** ____/____/_____

Birth Date: (M / D / Year) _____/_____/_____ **Height** ____**ft**____**inches** **Weight** _____**lbs**

REASON FOR TODAY'S EXAM _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

__High Blood Pressure __ DVT Lung Disease __ Stroke __High Cholesterol __ Pulmonary Embolus __ Asthma

__ Diabetes __Vein Trouble __ Tuberculosis __ Heart Trouble __ Pneumonia __ Kidney Disease __ Nervous Disorder

__Seasonal Allergies__ HIV__ Thyroid Problems__ Sinus__ Arthritis__ Hepatitis__ Drug Abuse/Alcoholism

__Tonsillitis __ Gastrointestinal __ Osteoporosis __ Joint Replacement __ Bleeding Tendencies __

Cancer: If Yes, What Type _____ Other: _____

History of Serious Injuries / Illnesses? **YES/NO** If yes, please describe below.

_____

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

_____

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions **immediate FAMILY** has had.

High Blood Pressure ___ DVT ____ Lung Disease ____ Stroke ____ High Cholesterol_____

Pulmonary Embolus ____Asthma ____ Diabetes _____ Vein Trouble _____ Tuberculosis_____ Heart Trouble_____

Pneumonia ____Kidney Disease_____ Nervous Disorder _____ Seasonal Allergies _____ HIV ____

Liver Disease ____ Seizures____ Ear Problems ____ Sinus ____ Drug Abuse / Alcoholism ____ Thyroid Problems _____

Arthritis ___ Tonsillitis ___ Joint Replacement ___ Hepatitis ____ Gastrointestinal ___ Osteoporosis ____

Cancer: Type_____

SOCIAL HISTORY: Occupation: _____ **Marital Status**:_____ **Children: Yes/ No_____**

Live Alone: Yes/ No Tobacco Use: Never/ In the Past/ Presently: How Much? _____ **How Long?** _____

Alcohol Use: Daily/ Occasional/ None/ Other substance use or abuse? Yes /No _____

SYSTEM REVIEW: Please describe any **active problem or symptom**. General Symptoms (i.e. fever, weight gain/loss, fatigue) _____

Eyes/Ears/Nose/Throat _____ Heart _____ Lung _____ Allergies/Rashes _____

Muscles/Bones/Joints _____ Psychiatric _____ Endocrine (Diabetes/Thyroid)_____

Bleeding/Lymph Nodes _____ Nerves _____ Skin and/or Breasts _____

OB/Genital/Urinary _____ Abdomen _____

ALLERGIC TO LATEX: Yes /No ALLERGIC TO MEDICATIONS: Yes /No PLEASE LIST:_____

_____

CURRENT MEDICATIONS: _____

HARRIS CHIROPRACTIC CLINIC
DR. MARK HARRIS, D.C.,C.C.S.P
3592 Aloma Ave. Suite #3
Winter Park, FL 32792
407-706-1420

Doctors of chiropractic, medical doctors, osteopaths, and physical therapists using manual therapy treatments for patients with neck problems are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause stroke, sometimes with serious neurological injury. The chances of this happening are extremely remote, approximately 1 per 1 million treatments. Appropriate tests will be performed on you to help identify if you may be susceptible to that kind of injury. If you have any questions about this please do not hesitate to speak with Dr. Harris.

I have read and understood the above statement, accept the risk mentioned, and hereby consent to treatment.

_____	_____
Patient's Signature	Date
_____	_____
Patient's Name (Printed)	Signature of Parent for Minor

For doctor's use only below this point.

_____

_____

_____

How will payment be made?_____Health Ins ____ Auto Ins_____Self-Pay_____Other

Are you covered by Medicare?_____Yes_____No

I hereby attest that the above information is true and accurate to the best of my knowledge. I hereby authorize the doctor or his representative to examine and treat me for my injuries and related illnesses as they deem appropriate. **I understand that fees for professional services from Harris Chiropractic Clinic are due and payable at the time of the visit**, unless other arrangements have been made. I understand that copies of my office records are available and may be obtained by filling out and signing the appropriate medical record release form, and that there may be a fee for this service, not to exceed the usual and customary rates.

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that as a courtesy Harris Chiropractic Clinic will assist me in submitting my bills to my insurance carrier and in making collection from the insurance company, and that any amount authorized to be paid directly to the Harris Chiropractic Clinic, will be credited to my account upon receipt. However, by affixing my signature **below I agree that I am personally responsible for full payment of all goods and services rendered me** through this clinic, regardless of the type and amount of insurance reimbursement provided for these services from third party payers.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name (Printed) Signature of parent for minors

Notice to all Patients

Welcome to our facility and practice! The following is important information regarding our patient policies. These policies aid us in ensuring proper care and customer services. If you have any questions or concerns, please do not hesitate in contacting our staff.

- Please sign in upon entering the facility for your scheduled appointment and check out with our receptionist prior to leaving. Please inform staff if your insurance, address or any other pertinent information changes.

- Payments are due at the time services are rendered unless prior arrangements have been made. Please be prepared to pay by credit card, check, or cash each office visit if necessary. **We will bill your insurance as a courtesy, but it is your responsibility to follow up on all insurance issues**. The billing department will do everything that can be done to resolve insurance issues, but it is your responsibility in the end.

- In order to provide all of our patients with proper care, it is imperative you arrive on-time for your scheduled appointment. It is imperative that you call if you are running late for your appointment, even being 5 minutes late may delay, shorten, or possibly cancel your appointment.

- **Failure to notify the clinic of cancellation of your scheduled massage therapy appointment at least 24 hours in advance will result in a $25 charge billed personally to you**. Your insurance company will NOT cover this fee.

- We value your time. If you have a limited amount of time for your session, please let us know in advance and we will accommodate you as best as we can.

Thank you for your patience and cooperation. By signing below, you certify that you agree to and understand the patient policies listed above.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By completing the lines below I,_____ authorize being contacted for practice reminders, information, and changes by:

PLEASE PRINT CLEARLY

Email at the following email address: _____
Telephone number(s) Cell Phone: _____
Other phone: _____
Is it okay to leave a voice message? Check here _____
Is it okay to leave a text message? Check here _____

Patient Name:_____ Date: _____

Name of parent, guardian, or patient's legal representative: _____

Signature of Patient, Guardian, or Patient's legal Representative: Date:

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI (Protected Health Information). This allows us to acknowledge that you are being treated here, discussion of your condition and/or allow them to pick up records on your behalf.

_____ _____

_____ _____

_____ _____

_____ _____