Kellie C. Baxter, DC • *Specializing in Chiropractic and Injury* 6875
Hickory Road Suite 110 • Woodstock, GA 30188
t. 770.345.1111 • f. 770.345.1788 • ReviveWoodstock.com

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HEALTH CENTER

New Patient Auto Accident Intake Forms

We require the following information to process your auto accident claim. If you do not have this information, please obtain it or we cannot treat you. If you have an attorney, we will work with your attorney directlyto obtain this information. If you do not have an attorney or MedPay, payment is due at time of service.

Personal Information

Name (First & Last): _____ Date: _____/_____/_____
Date of Birth: _____/_____/_____ Sex (Circle one): Male / Female
Marital Status: [ ]Single [ ]Married [ ]Widowed [ ]Divorced [ ]Separated Spouse's Name:_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone:_____ Cell Phone: _____ Email:_____
Our office has the capability to send you text & email reminders. Which do you prefer? (Circle one: Text Email Both

Emergency Contact

First Name: _____ Last Name: _____
Phone Number: _____ Relationship: [ ]Spouse [ ]Relative [ ]Friend [ ]Other_____
Your Primary Care Physician: _____ Physician Phone Number: _____

Employment Information

Business Name: _____ Occupation: _____
Address: _____ City:_____ State:_____ Zip:_____

Insurance Information

Insurance Carrier:_____ Policy Number:_____ Insured's DOB:_____
Who carries this policy? [ ]Self [ ]Spouse [ ]Parent Insured's Name:_____

Automobile Insurance/Attorney Information

Your Name:_____Driver of the vehicle you were in:_____
Name of YOUR auto insurance company:_____
Policy # _____ Claim # _____
Auto Insurance Phone # _____ Name of Adjuster_____
Amount of YOUR Medpay Coverage _____ Claim # if different than above_____

Your Attorney_____ Attorney Phone #_____
Driver of the other (AT FAULT) vehicle_____
Name of their auto insurance company:_____
Policy # _____ Claim # _____
Auto Insurance Phone # _____Name of Adjuster_____

AUTOMOBILE ACCIDENT HISTORY

1. Date of accident _____ **2. Time of accident** _____ **AM / PM** ◯ Day ◯ Dawn ◯ Dusk ◯ Dark

3. Road conditions at time of of accident: ◯ Wet ◯ Dry ◯ Snow ◯ Ice ◯ Other _____

4. Was the accident on the job? ◯ YES ◯ NO

5. Were you in a company vehicle? ◯ YES ◯ NO

6. Where were you seated in the vehicle? ◯ Driver ◯ Passenger front seat ◯ Passenger rear seat ◯ Other _____

7. Where you aware of the approaching impact, or did it catch you by surprise? ◯ Aware ◯ Surprised

8. Did you lose consciousness on impact? ◯ YES ◯ NO

9. Did you experience a flash of light or explosion in your head? ◯ YES ◯ NO

10. Did the police come to the accident scene? ◯ YES ◯ NO

11. Is there a police report? ◯ YES ◯ NO

12. Did you go to the hospital? ◯ YES ◯ NO **13. When?** ◯ Immediately ◯ ____ Hours Later ◯ ____ Days Later

14. What hospital? _____ **How long did you stay in the hospital?** _____

15. What did the hospital do for your injuries? (Collar / Splint / X-rays / Medication Etc.) ? _____

_____

16. What areas were X-rayed / MRI / CT Scan? _____

17. What was diagnosis? _____

18. What did they recommend for follow up care? _____

19. Was any other doctor consulted after the accident? ◯ YES ◯ NO **If yes, who?** _____

Specialty? _____ **Date Seen?** _____ **Type Treatment?** _____
How long did you treat? _____ **Treatment Frequency?** _____

Specialty? _____ **Date Seen?** _____ **Type Treatment?** _____
How long did you treat? _____ **Treatment Frequency?** _____

_____

Have you seen a chiropractor before? ◯ YES ◯ NO **If yes, please fill out the information below:**
Doctor's Name: _____ **Location:** _____ **Date of last visit:** _____

20. Were you wearing a seat belt? ◯ YES ◯ NO **If yes, did you receive any injury or bruise from the seat belt?** ◯ YES ◯ NO

21. Did your head hit the headrest? ◯ YES ◯ NO **If adjustable was the headrest position altered?** ◯ YES ◯ NO

22. Was the seat adjustment altered by the accident? ◯ YES ◯ NO **Was the seat broken by the accident?** ◯ YES ◯ NO

23. Did the air bag deploy? ◯ YES ◯ NO **If yes, did it strike you?** ◯ YES ◯ NO **Where?** _____

24. Which way was your headed pointed at impact? ◯ Straight ◯ Right ◯ Left **Which way was Body pointed?** ◯ Straight ◯ Right ◯ Left

25. Were your hands on the wheel? ◯ One on wheel ◯ Both on wheel ◯ Not applicable

26. List the year, make and model of *YOUR* car: YEAR_____ **MAKE** _____ **MODEL**_____

27. Was your car stopped at the time of impact? ◯ YES ◯ NO **If yes, was the drivers foot on the brake?** ◯ YES ◯ NO

28. If you were not stopped estimate the speed of the vehicle you were in _____**MPH.**

29. If your vehicle was moving at the time of impact was it : ◯ Slowing down ◯ Gaining speed ◯ Steady speed

OTHER CAR

30. List the year, make, and model of *OTHER* other car: YEAR_____ **MAKE** _____ **MODEL** _____

31. Was the other car moving at the time of impact? ◯ YES ◯ NO

32. What was the approximate speed of the other vehicle _____**MPH.**

33. Was the other vehicle at the time of impact : ◯ Slowing down ◯ Gaining speed ◯ Steady speed

34. Please describe to the best of your knowledge, what happened during the accident: _____

_____

_____

_____ *continue on next page if needed*

Patient name

Consultation Notes

Doctor's Initials
Dr. Kellie C. Baxter BS, DC

Patient name

35. At the time of the accident did you become or experience any of the following: ◯ Confused ◯ Disoriented ◯ Light headed
◯ Dizzy ◯ Ringing / buzzing in ears ◯ Nauseated ◯ Blurred vision ◯ Loss of balance ◯ Other _____

36. Do you stiill have any of those symptoms? ◯ YES ◯ NO **If yes, which ones?** _____

37. Please check off all symptoms you have had since the accident:

◯ Headache	◯ Tension	◯ Paralysis	◯ Neck Pain	◯ Joint Pain / Stiffness	◯ Weakness
◯ Migraine	◯ Nervousness	◯ Pinched Nerve	◯ Mid Back Pain	◯ Urinary Problems	◯ Vertigo
◯ Dizziness	◯ Loss of Sleep	◯ Fatigue	◯ Low Back Pain	◯ Pins & Needles	◯ Spasms
◯ Jaw Pain / Click	◯ Loss of Balance	◯ Irritability	◯ Sciatica	◯ Tingling	◯ Other
◯ Loss of Smell	◯ Vision Problems	◯ Depression	◯ Shoulder Pain	◯ Numbness	_____
◯ Difficulty Swallowing	◯ Sinus Pain	◯ Anxiety	◯ Arm / Leg pain	◯ Sore Muscles	_____
◯ Buzzing in Ears	◯ Fainting	◯ Light Bothers	◯ Chest Pain	◯ Stomach Upset	_____
◯ Loss of Memory	◯ Fever	◯ Cold Hands / Feet	◯ Digestive Problems	◯ Head Feels Heavy	

38. Does your job involve: ◯ Sitting ◯ Standing **How long?** _____ ◯ Lifting **How much?** _____ ◯ Bending ◯ Twisting / Turning

39. Physical activity at work: ◯ Sedentary ◯ Light Manual Labor ◯ Manual Labor ◯ Heavy Manual Labor

40. Have you missed work due to the accident? ◯ YES ◯ NO **If yes, how many days?** _____

41. Are your work activities restricted as a result of the accident? ◯ YES ◯ NO **If yes, explain** _____

42. Do any of your work activities aggravate your present complaints? ◯ YES ◯ NO **If yes, explain** _____

Job Description: _____ **Job Pressure / Stress:** ◯ YES ◯ NO

Is Your Job Duty Physical: ◯ YES ◯ NO **If yes, does your job involve heavy lifting?** ◯ YES ◯ NO

43. Hours of sleep per night? _____

44. Diet Habits: ◯ Skip Breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snack between meals ◯ Trying to lose weight

Coffee Intake: ◯ No ◯ Yes, How Many Cups daily? _____ **Water Intake:** ◯ No ◯ Yes, How Many Glasses daily? _____

45. Do you take pain relievers? ◯ Daily ◯ Weekly How much? _____ **Do you drink soft drinks?** ◯ Yes ◯ No

46. Do you have any pins, plates or screws? ◯ No ◯ Yes / Location: _____

Consultation Notes

Doctor's Initials
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Name: _____ Date_____

What is your chief complaint?

_____

_____

_____

_____

Have you ever had pain occur like this before? [ ]No [ ]Yes, when?_____

_____

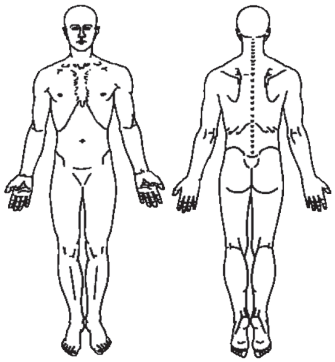
Is the pain is worse in the [ ]Morning [ ]Evening [ ] Can't tell a difference

Frequency you experience this symptom? [ ]Constant [ ]Frequent [ ]Intermittent [ ]Occasional

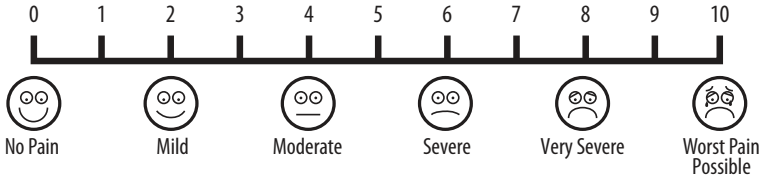
Describe the pain (How does it feel?) [ ]Numb [ ]Tingling [ ]Stiff [ ]Aching [ ]Stabbing [ ]Throbbing [ ]Dull [ ]Burning

Does the pain shoot or radiate to another area of your body? [ ]No [ ]Yes If yes, location:_____

Please circle all areas where you are experiencing symptoms on the figures to the right.



Please rate the intensity of your pain using the scale below.
Circle the number that best describes your pain.



Please list any additional complaints (in order of importance)

1._____When did it start?_____

2._____When did it start?_____

3._____When did it start?_____

Effects of current condition on your daily activities or performance (Check one most accurate for each activity)

Reaching overhead	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Bending / Turning	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Carrying / Lifting	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Sitting to standing	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Climbing Stairs	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Driving	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Computer Use	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Household Chores	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Lifting	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Concentration	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Bathing / Dressing	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Sleep	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Sitting	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Standing	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Walking	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Lying Down	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Yard Work	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Exercise	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Job Performance	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain

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Name: _____ Date_____

Current medications (please list any/all medications you are *currently* taking)

Medication	Dosage	For what condition?	Length of time using

Current supplements (please list any/all non-prescription items you are *currently* taking)

Supplement	Dosage	For what condition?	Length of time using

Family History

Some health issues are hereditary. Are there any hereditary health issues that anyone in your immediate family has that we should know about? _____
_____

Personal History

Illnesses:_____
_____
Allergies: [ ]No [ ]Yes If yes, please check all that apply: [ ]Seasonal [ ]Food_____ [ ]Medication_____
_____
Please check any of the following treatments you are currently having:
[ ]Massage Therapy [ ]Physical therapy [ ] Acupuncture [ ]Chemotherapy [ ]Dialysis [ ]Blood transfusions [ ]Herbs
[ ]Hormone replacement therapy [ ]Birth control [ ]Infusions [ ]IV Vitamin therapy [ ]Essential oils [ ]Homeopathy
Please list any prior injuries / concussions / fractures / accidents / hospitalizations: _____
_____
_____

Surgery History

[ ]I have not had any surgical procedures

[ ]Angioplasty	[ ]Tonsillectomy	[ ]Hysterectomy	[ ]Pacemaker insertion	[ ]Gallbladder
[ ]Appendectomy	[ ]Gallbladder	[ ]Joint Reconstruction	[ ]Rotator Cuff	[ ]D&C
[ ]Caesarian Section	[ ]Dental Surgery	[ ]Joint Replacement	[ ]Spinal Fusion	[ ]Cosmetic
[ ]Cardiac Cath.	[ ]Knee repair	[ ]Carpal tunnel	[ ]Laminectomy	[ ]Discectomy
[ ]Coronary Bypass	[ ]Mastectomy	[ ]Hernia	[ ]Other_____	

Acknowledgements /Agreement

Initials_____*FEMALES ONLY* I realize that x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge that I am not pregnant. Date of last menstrual period (_____/_____/_____)
Initials_____I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Initials_____To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresnted the presence, severity or cause of my health concern.

_____*Doctor's Initials Kellie Baxter. DC*

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HEALTH CENTER

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation for the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster, and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature X_____ Date: _____

Informed Consent For Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. There are some risks to treatment, including, but not limited to, muscle spasms, aggravating and /or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dizziness, headaches, discolorations, burns with modalities, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels best at the time, based upon the facts then known, and is in my best interests.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have had the opportunity to discuss with the doctor of chiropractic named below and / or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep my appointments as recommended to me by treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my examination from any other doctor. I will notify the facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ (print) have read, or had read to me, the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: X_____ Date: _____

Financial Responsibility

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. *Also, any cost that is required for collection procedures will be added to my balance and will also become my responsibility. Failure to make payment on your account will result in your dismissal from the practice. Please note that we have a $35 returned check fee on all checks returned to us from our bank for non-sufficient funds which will be charged to your patient account and you will be responsible to pay.* All co-payments, co-insurance amounts, deductibles, and / or other patient due balances must be paid in full at the time of your visit. Insurance is an agreement between me and my carrier and I am ultimately responsible for the payment of covered and non covered services. We are participating with Medicare. We will bill Medicare for you. Please note federal law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill it after Medicare pays. Medicare at this time does not cover exams or x-rays if the billing doctor is a Doctor of Chiropractic. Medicare also does not cover wellness care / preventative / maintenance care, progress exams, therapies, massage therapy, or supplements. You will be responsible for these charges at the time of service. We accept cash, checks, Visa, Mastercard, American Express, Discover, Apple Pay and Care Credit.

Patient or Guardian Signature: X_____ Date: _____