PATIENT INTAKE PAPERWORK

Home Phone ___________________ Cell Phone ___________________
Name ____
Address ____________________________City _________________State ______Zip_________
Date of Birth _____/_____/_____ Age _______
Height _______Weight _______
Email address ____
Occupation __________________________ Employer __________________________________

Emergency Contact Information:
Name of Emergency Contact: ___________________________________
Phone Number: ___________________________________
Relationship: ________________________________

Name of the driver of the vehicle in which you were injured: ____________________________
Insurance Company: ____________________________ Phone: _____________________________
Insurance Company Address: ____
Policy number: ___________________________ Claim Number: ________________________________

Name of the driver of the other vehicle: ____________________________
Insurance Company: ____________________________ Phone: _____________________________
Insurance Company Address: ____
Policy number: ___________________________ Claim Number: ________________________________

How did you hear about our office? ____

Patient Signature: __________________________ Date: ___________________

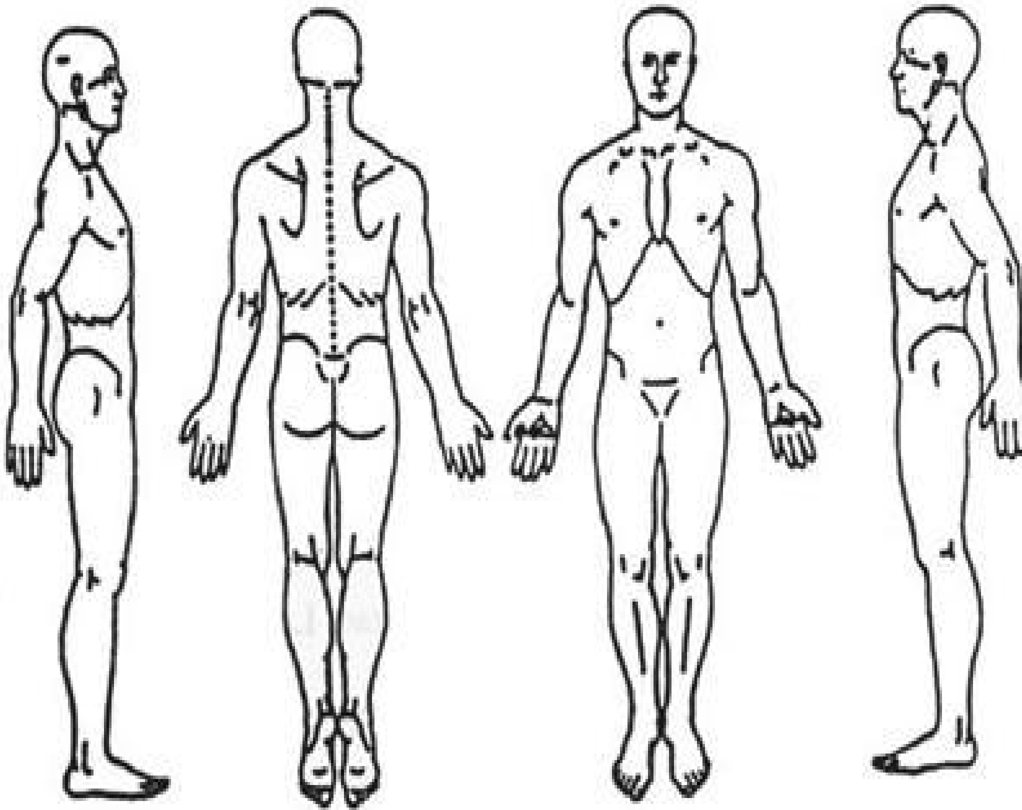
WESTMINSTER
SPINE + INJURY + LASER
CENTER

Body Pain Chart

Patient Name:

On the body chart below please use the key to describe in the best detail possible where your symptoms are following the collision be sure to include any arm, hand, leg or foot complaints:

Numbness: = = = =   Pins & Needles: 0 0 0 0   Burning: x x x x   Ache: ////   Sharp: ^ ^ ^ ^



Patient Signature: ______________________ Date: __________________

Patient Name:

Time and Date of the collision:

From what direction was your vehicle struck: front, rear, drivers side, passenger side, front drivers side, front passengers side, rear drivers side, rear passengers side. *Circle all areas damaged.*

Was your vehicle stopped at the time of the collision?
Did your vehicle strike any additional objects after the initial collision?
What was your exact position in the vehicle during the collision:
Were you wearing your seatbelt?
What direction were you looking when the collision occurred?
Were both hands on the wheel?
Was your foot depressing the brake at the time of collision?
Were the airbags deployed? If yes, what part of your body made contact with the airbag?
Did your knee or elbow strike anything in the vehicle?
Did you strike your head inside the vehicle?
Did you see the collision coming?
Did you brace for the collision?
Did your wrists, hands, feet, or ankles have any pain following the accident?
Did you lose consciousness at any time during or after the collision?
Do you remember specifically unbuckling your seatbelt?
Do you remember exiting the vehicle?
Did you have pain immediately following the collision, if yes where?
Does your vehicle have a towing hitch?
Were the police contacted / at the scene?
Were EMS present on scene?
Did you go to the ER or Urgent Care after the collision?

Patient Signature: ________________________ Date: ___________________

History of Present Illness

Patient Name:

Please list each symptom separately in order of severity. Then answer the associated questions. Be sure to list each location on the body map provided.

1.
-When did this complaint start:
-What makes it better: What makes it worse:
-What does it feel like? Sharp, dull, burning, achy, tingling, numb:
-Does your pain radiate (shooting from a central point to somewhere else?)
-On a scale from 0 to 10 please list where your pain is currently with 0 being no pain at all and 10 being unbearable pain that makes you feel like you should be taken to the emergency room:
-What is your pain at it's best from 0 to 10? Pain at it's worse?
-What percent of your waking hours is this pain with you?

2.
-When did this complaint start:
-What makes it better: What makes it worse:
-What does it feel like? Sharp, dull, burning, achy, tingling, numb:
-Does your pain radiate (shooting from a central point to somewhere else?)
-On a scale from 0 to 10 where is this pain:
-What is your pain at it's best from 0 to 10? Pain at it's worse?
-What percent of your waking hours is this pain with you?

3.
-When did this complaint start:
-What makes it better: What makes it worse:
-What does it feel like? Sharp, dull, burning, achy, tingling, numb:
-Does your pain radiate (shooting from a central point to somewhere else?)
-On a scale from 0 to 10 where is this pain:
-What is your pain at it's best from 0 to 10? Pain at it's worse?
-What percent of your waking hours is this pain with you?

Patient Signature: ________________________ **Date:** ________________.

4.

-When did this complaint start:
-What makes it better: What makes it worse:
-What does it feel like? Sharp, dull, burning, achy, tingling, numb:
-Does your pain radiate (shooting from a central point to somewhere else?)
-On a scale from 0 to 10 where is this pain:
-What is your pain at it's best from 0 to 10? Pain at it's worse?
-What percent of your waking hours is this pain with you?

5.

-When did this complaint start:
-What makes it better: What makes it worse:
-What does it feel like? Sharp, dull, burning, achy, tingling, numb:
-Does your pain radiate (shooting from a central point to somewhere else?)
-On a scale from 0 to 10 where is this pain:
-What is your pain at it's best from 0 to 10? Pain at it's worse?
-What percent of your waking hours is this pain with you?

6.

-When did this complaint start:
-What makes it better: What makes it worse:
-What does it feel like? Sharp, dull, burning, achy, tingling, numb:
-Does your pain radiate (shooting from a central point to somewhere else?)
-On a scale from 0 to 10 where is this pain:
-What is your pain at it's best from 0 to 10? Pain at it's worse?
-What percent of your waking hours is this pain with you?

Have any of your symptoms that appeared following the collision resolved on their own before your visit today?

Have you been using any home therapy? Circle all that apply: ice, heat, pain relievers, massager, stretching, yoga, TENS unit, self massage

SLEEP QUESTIONNAIRE

Prior to this event how many hours of sleep would you normally get?
How many hours of sleep have you been getting since this event?
List any factors that are currently interfering with your sleep (pain, anxiety, nightmares, flashbacks):

Patient Signature: ________________________ Date: ___________________

Patient Name:

PAST MEDICAL HISTORY:

Were you seen by EMS at the scene of the accident?
Were you taken by EMS to the ER?
If yes, did the ER take any x-rays, MRI's, CT's, other tests?
If yes, were you released to return home? If yes, were you given any instructions or medication?

Have you seen your PCP for this complaint:
Have you seen any other medical providers for this complaint:
Please list any other imaging related to this event (CT, X-rays, MRI, PET Scan, Ultrasound):

It is important to gather information related to your past medical history to assess if previous medical records could be helpful in your treatment for this event. Below please list all past providers including PCP, Podiatrist, Orthopedic, Chiropractic, ect:

Provider:	Phone:	Reason for visit:
Provider:	Phone:	Reason for visit:
Provider:	Phone:	Reason for visit:
Provider:	Phone:	Reason for visit:

Please list ALL past surgeries you have had:
Last full physical exam with your PCP:
Do you currently have or have you ever been diagnosed with any type of seizure disorder?

MEDICATIONS & ALLERGIES:

Do you have any allergies to medications, latex gloves, ect?
Are you currently taking any pain relievers, muscle relaxers, or neurontin/gabapentin?
Please list all current medications:
Are you currently taking supplements, if yes please list:

SOCIAL AND FAMILY HISTORY:

Do you smoke, use recreational drugs, or alcohol?
Do you have a family history of: (circle those that apply) arthritis, diabetes, hypertension, stroke, heart disease, cancer. Any other family history of disease?

Patient Signature: ________________________ Date: ___________________

PAIN DISABILITY QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

____
Examiner

OTHER COMMENTS:

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

Activities of Daily Living

Patient Name:

Activities of Daily Living

Has it been difficult to perform your activities of daily living?
Has it been difficult to perform your duties at work?
List any activities or duties that are still being limited by your symptoms by completing additional Current Symptoms & Impaired Activities sheets:

Impaired Activities

(Circle ALL activities that have been affected following the accident)

Daily Activities

Bathing/showering Bending Brushing Teeth Dressing Driving Car Dining Out
Lifting Vacationing Eating Watching TV Movie Going Church Events Sleeping
Dressing Sexual Relations Reading Standing Child Care Traveling Sitting
Shaving Shampooing Hair Social Events Shopping Computer

Domestic Activities

Cooking Ironing House Cleaning Laundry Washing Dishes Vacuuming Dusting
Lawn Care/Gardening

Work Activities

Sitting Standing Lifting Using Telephone Computer Work Reading Typing Writing

Hobby Activities

Sports, Hobbies? List all the apply here:

Please list any activities that you have had to perform despite pain, due to financial/family/personal needs or obligations (duties under duress):

Cognitive and Emotional Symptoms

(Circle ALL activities that have been affected following the accident)

Memory Issues Reading Problems Apathy Impaired Comprehension Loss of Libido
Blurred Vision Irritability Dizziness Loss of Coordination Anxiety Depression
Flashbacks To The Accident Ringing In Ears Social Withdrawal Panic Attacks

Patient Signature: ________________________ Date: ___________________

All information contained in this packet has been thoroughly reviewed by Physician:
Physician Signature: ________________________ Date: ___________________

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

§ Protected health information may be disclosed or used for treatment, payment, or health care operations.
§ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
§ The Practice reserves the right to change the Notice of Privacy Practices.
§ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
§ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
§ The Practice may condition receipt of treatment upon the execution of the Consent.

This consent was signed by: ____
Printed Name-Patient or Representative

____ _____/_____/_____
Signature **Date**

INFORMED CONSENT TO TREAT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct diagnostic or examination procedures if indicated. These may include: physical examination, palpation, reflex testing, neurological evaluation, blood pressure, pulse oximetry, temperature,

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

As with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, arterial dissections, dislocations, strains, and sprains. ALL efforts and clinical diagnostics will be taken to ensure if any predisposition or risk for injury exist prior to treatment, then treatment will be altered to ensure the lowest possible risk.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ___________________________ Signature: ________________________ Date:

Parent or Guardian: _______________________ Signature: _________________________Date:

MEDICAL PAYMENTS RELEASE AUTHORIZATION

Patient's Name: ______________________________ Date of Injury:__________________

Upon receiving proceeds on my behalf, I hereby authorize and direct my **Attorney / Insurance Company / 3rd-Party-payor** to pay directly to Dr. Cameron A. Hall D.C. such sums from any settlement, judgment, verdict, medical payments coverage, or 3rd party funds from my personal injury claim based on the accident referenced above, as may be necessary, to pay in full Westminster Spine, Injury, & Laser Center for reasonable and necessary services rendered on my behalf. I acknowledge that I alone, not my attorney, am responsible for my medical expenses. This lien shall be irrevocable and shall be valid and enforceable out of the net proceeds of my settlement, judgment or verdict. Net proceeds means the gross amount recovered, less any attorney fees and costs. This lien applies to sums currently owed, and to sums which may be incurred in the future, up to the time of settlement of my personal injury claim. In exchange for this lien the medical provider below will refrain from any collection efforts until my personal injury claim is resolved and will provide copies of the patient's current bills and balance to the patient's attorney/ insurance carrier/3rd-party-payor.

Patient's signature: __________________ Name printed:__________________ Date: _____________

Treating Doctor: Dr. Cameron A. Hall D.C. 7535 W 92nd Ave Ste, 600 Westminster CO 80021

The undersigned, being the attorney of record for the above patient, does hereby agree to withhold and pay such sums from the patient's portion of any settlement, judgment or verdict as set forth above for the benefit of Dr. Cameron A. Hall D.C.

Attorney Signature: ________________________ Attorney Name Printed:____________________

Date: _________________

The undersigned, being a representative of the Insurance Carrier/3rd Party payor for the above patient, does hereby agree to withhold and pay such sums from the patient's portion of any settlement, judgment or verdict as set forth above for the benefit of Dr. Cameron Hall D.C.

Insurance Representative Signature: ________________________ Printed: ____________________

Date:_________________

A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

INSURANCE VERIFICATION AUTHORIZATION

I authorize Westminster Spine & Injury to verify my insurance benefits for future services at this facility. This authorization includes: Health Insurance, Medicare/Medicaid, Auto Insurance (including policy information, coverage amounts, and Medical Payments Coverage), and Workman's Comp Insurance (if I was involved in a work related injury).

Patient Signature ________________________________ Date ____________________

Print Name ________________________________

MEDICAL PAYMENTS COVERAGE, 3RD PARTY PAYOR, LIEN, & HEALTH INSURANCE COVERAGE INFORMED CONSENT

Please read this paragraph carefully as it pertains to how your care is paid for:

Colorado State Law mandates that all individuals must be covered by a minimum $5,000 Medical Payments Coverage (MedPay) by their Auto Insurance Company. These monies are to be used in the event of a Motor Vehicle Accident for medical services and treatments related to injuries sustained in the accident. This coverage is mandatory unless otherwise waived by the individual insured and using it is your right and by Colorado State Law using this can not increase your insurance premiums. This coverage pertains to both the at-fault and not at-fault individuals. If this Medical Payments Coverage is available it must be used before Health Insurance Coverage, 3rd Party (at-fault insurance) or other parties could be billed. I authorize Dr. Cameron A. Hall D.C. to verify if I have Medical Payments Coverage and I understand that is my right under Colorado State Law to use this to pay for any medical expenses that I incur as a result of this accident. If Medical Payments Coverage is not available the at-fault or 3rd Party Insurance Company shall be billed for treatments relating to this accident. If you are the at-fault party and Medical Payments Coverage is not available through your auto insurance company then health insurance or out of pocket payments will be used for your care. I authorize Westminster Spine & Injury to verify Medical Payments Coverage and if appropriate to open a Medical Payments Claim on my behalf.

Patient Signature ________________________________ Date ____________________

Print Name ________________________________

MEDICAL RECORDS RELEASE AUTHORIZATION

I ___________________________ authorize the release of medical records to Dr. Cameron A. Hall D.C. for review and treatment of an injury that occurred __________________.

I authorize Dr. Cameron A. Hall D.C. to copy and inform my attorney, insurance company, primary care provider, and any other medical provider related to my care and treatment on my diagnosis, treatment, and care related to the above injury.

This request includes all of the following information:
Chart notes, procedure notes, surgical notes, physician notes, PA notes, NP notes, diagnostic reports, imaging reports, and laboratory reports.
Other:

Please fax or mail records to:
Westminster Spine, Injury, & Laser Center
7535 W 92nd Ave Ste 600
Westminster CO 80021
(303)-425-9557 p
(303)-425-3399 f

This request will remain valid for 180 days from the date signed by the patient and may be revoked by the patient at any time with written consent. All health information is protected by law.

Patient Signature __________________________________ Date ___________________

Print Name __________________________________