Personal Injury Health Record

Welcome to Olar Family Chiropractic!

File Number:__________

Name:____Date:___________________SSN:______________
Address:____________________________________City:________________ State:________ ZIP:_____________
E-mail:____ Date of Birth: ____/______/______
Cell #: ______________________ Home #:_________________________ Work #:_________________________
Occupation:_______________________________ Employers Name:___________________________________
Marital Status: S M D W Spouse Name:___________________________________ # of Children:________

Injury Date_______________State occurred________________
Auto Ins. Name:_____________________________________
Address____
City_____________________State____________Zip________
Claim #:_______________________________________
Adjuster Name____________________________
Contact #:____________________________Fax#____________
Med Pay: YES NO
Direct payment to provider YES NO

Party at Faults Insurance Name:__________________________
Address:____
City________________________State_________Zip_______
Lawyer Name____
Address____
City_____________________State____________Zip________
Contact #:__________________________Fax#_____________

Accepts/Requires Assignment of Benefits YES NO

Please (√) check mark your answer:

Your Vehicle:

What was your location in the vehicle?

☐ Driver ☐ Passenger ☐ Back Seat Passenger

What was the vehicle you were in doing?

☐ Stopping ☐ Slowing down ☐ Moving ☐ Accelerating
☐ Turning

How did this vehicle strike the vehicle you were in?

☐ Head on ☐ From Right ☐ From Left ☐ Rear ended
☐ Side swiped ☐ Other:__________________________

Did any of your body parts hit the following?

☐ Steering wheel ☐ Right window
☐ Dashboard ☐ Left window
☐ Windshield ☐ Ceiling
☐ Right side door ☐ Console
☐ Left side door ☐ Shift lever
☐ Armrest ☐ Front Seat
☐ Headrest ☐ Rear view mirror

At the Moment of Impact:

Were you prepare for the accident?

☐ Complete Surprise ☐ Braced for Impact

Were you wearing a seat belt?

☐ Yes ☐ No

Did the air bags deploy?

☐ Yes ☐ No

What was you body position at time of Impact?

☐ Straight ☐ Slouched forward ☐ Body Rotated
☐ Head turned ☐ Don't Recall

What direction was your body Thrown?

☐ Forward ☐ Backward ☐ Sideways ☐ Don't Recall

Did you lose Consciousness?

☐ Yes ☐ No ☐ Don't Know

How did you feel?

☐ Confused ☐ Dazed ☐ Dizzy ☐ Nervous ☐ Weak
☐ Other:_________________________________

Where did you immediately develop pain?

☐ Head
☐ Neck
☐ Lower Back
☐ Hips R L
☐ Thighs R L
☐ Knees R L
☐ Legs R L
☐ Feet R L
☐ Upper Mid Back
☐ Chest/Rib Cage
☐ Abdomen
☐ Shoulder R L
☐ Arms R L
☐ Elbows R L
☐ Forearm R L
☐ Wrists R L
☐ Hands R L
☐ Other:________________

If there were lacerations (cuts), where were they?

☐ Upper body ☐ Lower Body ☐ None

What type of emergency care did you receive?

☐ None ☐ Bandages ☐ Splint ☐ Brace ☐ Neck Collar
☐ Other:______________________________

Since your accident have you suffered from?

☐ Blurred Vision
☐ Nausea
☐ Double Vision
☐ Vomiting
☐ Constipation
☐ Inability to hold urine
☐ Frequent Urination
☐ Ringing in ears
☐ Anxiety
☐ Restlessness
☐ Depression
☐ Insomnia
☐ Mood swings
☐ Nervousness
☐ Tension
☐ Weight Change
☐ Chest Pain
☐ Palpitations
☐ Difficulty breathing
☐ Reduced Vision
☐ Impaired Hearing
☐ Painful Urination
☐ Convulsions
☐ Diarrhea
☐ Dizziness
☐ Headaches
☐ Light Sensitivity
☐ Reduced Appetite
☐ Loss of Balance
☐ Weakness
☐ Fatigue
☐ Fainting
☐ Poor Memory
☐ Other:______________

Destination after Accident/Injury:

Where did you go?

☐ Hospital ☐ Home ☐ Work ☐ School
☐ Other:__________

By whom were you driven?

☐ Myself ☐ Ambulance ☐ Friend ☐ Family member
☐ Other:_____

If you went to the hospital:

When did you go:______________________
Hospital name:________________________

Examinations performed at the hospital:

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other:____________

What Treatment administered at the hospital?

☐ Medication ☐ Ice pack ☐ Neck Collar ☐ Surgery
☐ Sutures ☐ Other:____________________________

Limitations:

Areas limited as a result of this accident?

☐ Daily Living
☐ Occupation/work
☐ Recreational Activities
☐ Other:__________

Have you missed work due to this accident?

☐ No
☐ No, but limited work activity
☐ Yes, From: ____/____/____ to ____/____/_____

Did you Self treat your symptoms?

☐ Ice ☐ Heat ☐ Bed Rest ☐ Over the counter meds
☐ Other:________________________

Movements Restricted:

☐ Bending ☐ Sit to Stand ☐ Lying Down
☐ Twisting/Turning ☐ Walking ☐ Other________

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physicians's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	**RELATIONSHIP TO PATIENT:**
SIGNATURE:	**DATE:**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

I authorize the release of any chiropractic or other information necessary to process this claim.

Notice: I direct any INSURANCE COMPANY, ATTORNEY, or OTHER PERSON who holds or later holds any proceeds from my claim to apply any proceeds from my claim to my total account balance out of the total proceeds held in my behalf, unless OLAR FAMILY CHIROPRACTIC confirms prior payment of it in writing. "Total proceeds" held by an attorney for my claim shall mean proceeds after deduction of attorney fees.

I authorize release of assignment of benefits when deemed necessary to process your insurance auto claim(s) on your behalf.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	**DATE:**

AUTHORIZATION FOR CARE OF MINOR

I, ___________________________ being the parent or legal guardian of _________________________have read and fully understand the above Informed Consent and hereby grant permission for my child/children to receive chiropractic care.