KARE
CHIROPRACTIC
"Because We Care About Your Health"

Accident/Injury Patient Paperwork

Please complete this form to the best of your ability. If you need help our receptionist will gladly assist you!

Today's Date:_____

Legal Name : _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex:☐ Female ☐ Male

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____-_____-_____

Email: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you give us permission to contact this person in the event of an emergency? ☐ Yes ☐ No

How did you hear about our office? _____

When did your condition begin? _____

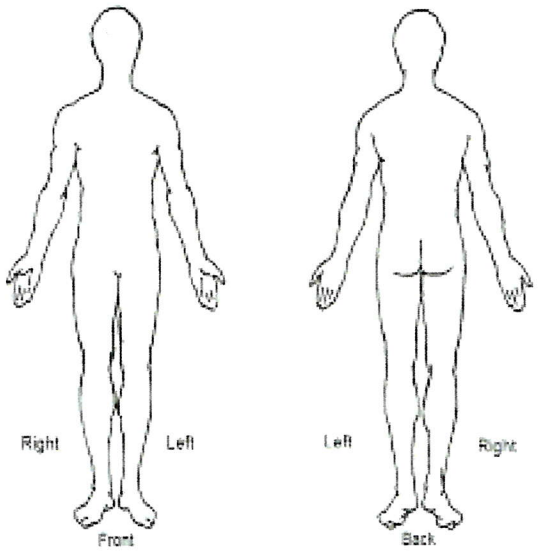
Other Doctors seen for this condition? _____

Type of previous Treatment and/or Surgery for this condition? _____

Results of previous treatment: ☐ Good ☐ Fair ☐ Poor ☐ Other: _____

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of Prior Condition: _____

MARK AREAS OF PAIN ON THE FIGURE BELOW



List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Have you Had Chiropractic care before?

☐ Yes ☐ No

If yes, name of Chiropractor: _____

Conditions Treated: _____

Results of Treatment: _____

Date of last visit: _____

Primary Care Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current medications, vitamins, and supplements you are presently taking: _____

_____

_____

Allergies (medicine, food, environment): _____

Previous Surgeries: _____

Do you suffer from any serious conditions and/or illnesses other than which you are now consulting us?

_____

Have you been treated for any health conditions in the last year? ☐ Yes ☐ No

If YES, please explain: _____

Check all PERSONAL history or any symptoms that apply to you:

☐ Headache	☐ Joint Replacement	☐ Concussion
☐ Cold/Tingling/Numbness in arms/hands	☐ Chest Pain	☐ Metal/Screws/Implants
☐ Knocked unconscious	☐ Fainting	☐ Cervical Whiplash
☐ Unexplained weight loss	☐ Electronic Implant	☐ Birth Defects/Complications
☐ Osteoporosis	☐ Neck pain/stiffness	☐ Pacemaker
☐ Cold/Tingling/Numbness in legs/toes	☐ Tumor	☐ Knee Pain
☐ Ruptured Spinal Disc	☐ Cyst	☐ Slipped Spinal Disc
☐ Ear Infections	☐ Fatigue	☐ Pinched Nerve
☐ Asthma	☐ Back Pain/Stiffness	☐ Spinal Injury
☐ Loss of Balance/Dizziness	☐ Spinal Infections	☐ Arm Pain
☐ Hip Pain	☐ Spinal Taps	☐ Leg Pain
☐ Night Sweats	☐ Diabetes	☐ Pain Between Shoulders
☐ Allergies	☐ Shoulder Pain	☐ High Blood Pressure
☐ Loss of Sleep	☐ Shortness of Breath	☐ Stroke
☐ Stomach/Digestive Problems	☐ Fever	☐ Aneurysm
☐ Walking Problems	☐ Blood in Urine	☐ Convulsions
☐ Fractured Bones	☐ Night Pain	☐ Seizures
☐ Pain Unrelieved by Rest	☐ Scoliosis	☐ Memory Lapse
☐ Bowel/Bladder Problems	☐ Other:_____	

For Women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

ACCIDENT OR INJURY INFORMATION:

Is your condition related to an accident or injury? ☐ Yes ☐ No

If yes, please check all that apply:

☐ Employment-related injury (Workers' Compensation)

☐ Automobile accident

☐ Slip and fall

☐ Other accident or injury (please describe): _____

TREATMENT AUTHORIZATION:

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amounts become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

Patient/Parent/Guardian Signature(X): _____ **Date:** _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, may have some level of risk all while offering considerable benefit. 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 the 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 a stroke. Prior to receiving chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you, along with a care plan, prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary and to the chiropractic care (including spinal manipulations).

Patient/Parent/Guardian Signature(X): _____ **Date:** _____

I have been offered and understand the **Patient Health Information Consent Form.**

I have been offered and understand the **Missed Appointment Policy** and the **$50 fee** associated.

Patient/Parent/Guardian Signature(X): _____ **Date:** _____

CONSENT TO TREAT A MINOR:

I (we) being the parents, guardian or custodian of the minor being:

Name: _____ Age: _____

do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Patient Name(Print): _____

Parent/Guardian Name(Print): _____

Patient/Parent/Guardian Signature(X): _____ **Date:** _____