MVA/WC INTAKE FORM
New Patient

PLEASE FILL OUT COMPLETELY

Name: _____ **Today's Date:** _____

Preferred Name: _____ Name Changes: _____

Gender: M_____ F_____ Other _____ DOB _____ AGE _____

Address: _____ City: _____ State _____ Zip _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Marital Status: S M D P W **Spouse/Partner Name:** _____

Cell Phone: _____ Work Phone: _____

Emergency Contact Other Than Spouse/Partner: _____ Phone: _____

How did you hear about us?_____

Your Occupation: _____ **Employer:** _____

Requires a lot of ___Sitting ___ Standing ___Walking ___Lifting

Typical Schedule ___Days ___Evenings ___Shift

Level of Education ___ High School ___Some College ___College Grad ___Post Grad

Medical Insurance: _____

Insured's Name: _____ ID# _____

Accident Information

Date of Accident_____ Time_____ am/pm Location_____

Have you missed any work? Yes No If yes, how many days? _____

Type of Accident: Auto Accident Work Related

Auto Accident:

What kind of vehicle(s) were involved? _____

Were you a: Driver _____ Passenger _____ Pedestrian _____

If a passenger, please indicate your location in the car _____

Was your vehicle moving when the accident occurred? Yes No

Did you see the accident coming? Yes No

At the time of the impact were you looking straight ahead? Yes No

Did the airbags deploy? Yes No Were you wearing a seatbelt? Yes No

Did your vehicle hit the other vehicles(s)? Yes No Where? _____

Did the other vehicle(s) hit your vehicle? Yes No Where? _____

Were you treated in the ER? Yes No Were you transported by ambulance? Yes No

Did you require post-accident hospitalization? Yes No

Was the accident reported to police? Yes No

Were Citations issued? Yes No To whom? _____

Describe circumstances surrounding the accident:

_____

_____

_____

_____

Work Related Accident:

Type of Equipment, machinery, and/or object involved in accident? _____

Was the accident reported to the supervisor and/or employer? Yes No

Has a worker's compensation claim been filed? Yes No

Describe circumstances surrounding the accident:

_____

_____

_____

_____

Print Patient Name:_____ **Date:** _____

Location of Primary Complaint _____

Please circle the type of complaint/pain: dull aching sharp shooting burning throbbing deep nagging Other_____

Does this complaint/pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Frequency of pain, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint_____

Location of Secondary Complaint _____

Please circle the type of complaint/pain: dull aching sharp shooting burning throbbing deep nagging Other _____

Does this complaint/pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Frequency of pain, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint _____

Previous injury, trauma, concussion or broken bones? _____

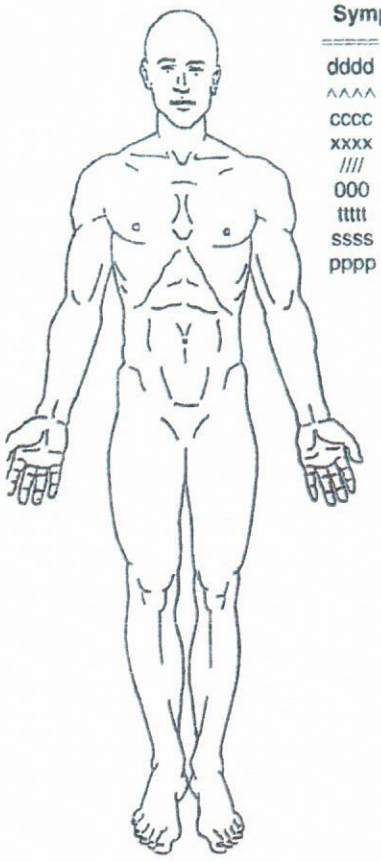
When? _____

Which bone(s)? _____

Print Patient Name:_____ **Date:**_____

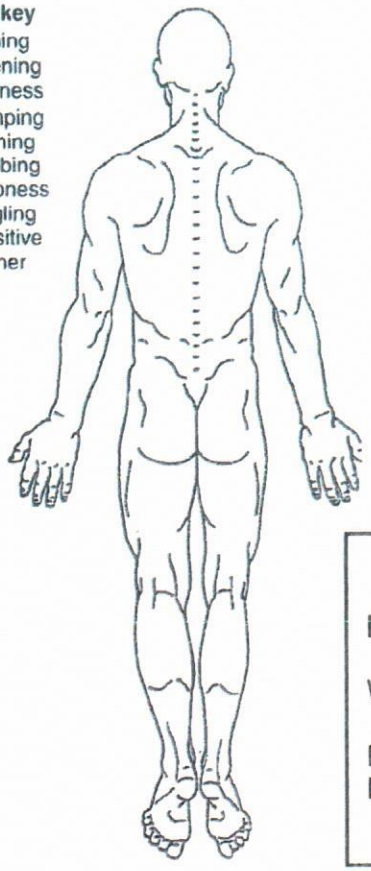
PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:



Symptom key

=====	Aching
dddd	Stiffening
^^^^	Tightness
cccc	Cramping
xxxx	Burning
////	Stabbing
000	Numbness
ttttt	Tingling
ssss	Sensitive
pppp	Other



Height_____

Weight_____

Blood Pressure_____

Right Left Left Right

Recreational Activities and Hobbies

__Backpacking	__Biking	__Boating	__Running
__Golfing	__Racquetball	__Tennis	__Rock Climbing
__Skiing	__Soccer	__Swimming	__Walking
__Weight Lifting	__Football	__Basketball	__Volleyball
__Cross Fit	__Dancing	__Yoga	

Other: _____

Print Patient Name:_____ **Date:**_____

Review of Systems

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for awhile, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, Please circle all that apply, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Constitution (General Health) □ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior or current diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat □ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

Heart & Blood Vessels □ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Respiratory (Lungs & Breathing) □ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) □ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) □ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) □ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Skin, Hair & Breast □ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) □ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) □ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) □ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) □ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunoligic □ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Print Patient Name_____ **Date** _____

Personal and Family Health History

__Arthritis Parent / Sibling
__Cholesterol Parent/Sibling
__Diabetes Parent / Sibling
__Heart Problem Parent / Sibling
__Thyroid Parent / Sibling
__Cancer Parent / Sibling
__Psychiatric Parent / Sibling
__ Other _____
__HB Pressure Parent / Sibling
__ Stroke Parent / Sibling

Immediate Family Deaths

Relation_____ Age at Death _____ Cause_____
Relation_____ Age at Death _____ Cause_____
Relation_____ Age at Death _____ Cause_____
Relation_____ Age at Death _____ Cause_____

Pregnancies/Children

Date_____ Outcome _____
Date_____ Outcome_____
Date_____ Outcome_____
Date_____ Outcome_____
Date_____ Outcome_____

Date of your last menstrual period? _____ Are you pregnant now? _____

Please indicate if substance use is [M] medicinal or [R] recreational.

__ Alcohol Past /Present
__Barbiturates Past/Present
__Crystal Meth Past/Present
__Marijuana Past /Present
__Amphetamine Past/Present
__Other_____
__Heroine Past /Present
__Cocaine Past/Present

Surgeries

___Appendectomy
___ACL
___Cardiovascular
___Joint Replacement
Specify _____
___Gall Bladder
___Lumbar Disc
___Cervical Disc
___Mastectomy
Partial____ Full___
___Rotator Cuff
___Prostatectomy
___Prostate
___Hysterectomy
Partial___ Full___
___Other_____
___Other_____
___Other_____
___Other_____

Prescription Medications (Please List)

_____
_____
_____

Over the Counter Medications and or Supplements (Please List)

_____
_____
_____

Print Patient Name _____ **Date** _____

NECK Pain and Disability Questionnaire – Please CHOOSE ONE from each section.

Section 1 – Pain Intensity
___I have no pain at the moment.
___The pain is very mild at the moment.
___The pain is moderate at the moment
___The pain is fairly severe at the moment.
___The pain is very severe at the moment.
___The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc)
___I can look after myself normally without causing extra pain.
___I can look after myself normally but it causes extra pain.
___I am slow and careful because it is painful for me to look after myself.
___I need some help but manage most of my personal care.
___I need help every day in most aspects of personal care.
___I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting
___I can lift heavy weight without extra pain.
___I can lift heavy weight but it causes extra pain.
___I cannot lift heavy weight off the floor, but I can manage if conveniently positioned, like on a table.
___I cannot lift heavy weight, but I can manage light to medium Weight, if conveniently positioned.
___I cannot lift any weight due to neck pain.

Section 4 – Reading
___I can read as much as I want to with no pain in my neck.
___I can read as much as I want to with slight neck pain.
___I can read as much as I want to with moderate neck pain.
___I cannot read as much as I want to due to moderate neck pain
___I can hardly read at all because of severe neck pain.

Section 5 – Headaches
___I have no headaches at all.
___I have slight headaches that occur infrequently.
___I have moderate headaches that occur infrequently.
___I have frequent moderate headaches.
___I have frequent severe headaches.
___I have severe headaches all the time.

Section 6 – Concentration
___ I can concentrate fully when I want to with no difficulty.
___I can concentrate fully when I want to with slight difficulty
___I have a fair degree of difficulty in concentrating when I want to.
___I have a great deal of difficulty in concentrating when I want to.
___I cannot concentrate at all.

Section 7 - Work
___I can do as much work as I want to.
___I can only do my usual work, but no more.
___I can do most of my usual work, but no more.
___I cannot do my usual work.
___ I can barely do any work at all.
___I cannot do any work at all.

Section 8 – Driving
___I can drive my car without any neck pain.
___I can drive my car as long as I want with slight neck pain.
___I can drive my car as long as I want with moderate neck pain.
___I cannot drive my car as long as I want.
___I can hardly drive at all because of severe neck pain.
___I cannot drive my car at all.

Section 9 – Sleeping
___I have no trouble sleeping.
___My sleep is slightly disturbed (less than 1 hour sleepless)
___My sleep is mildly disturbed (1 hour sleepless)
___My sleep is moderately disturbed (2 to 3 hours sleepless)
___My sleep is greatly disturbed (4 to 5 hours sleepless)
___My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10 – Recreation
___I am able to engage in all my recreational activities with no neck pain.
___I am able to engage in all my recreational activities with some neck pain.
___I am able to engage in most, but not all of my usual recreational activities.
___I am able to engage in a few of my usual recreational activities.
___I can hardly do any recreation activities.
___I cannot do any recreation activities due to neck pain.

OVERALL PAIN SCALE (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

Patient Name (Print) _____ Patient Signature _____ Date _____

For Office Use Only

_____ x 2 = _____ _____
Total Points Disability Percentage Rating Scale

BACK Pain and Disability Questionnaire – Please CHOOSE ONE from each section.

Section 1 – Pain Intensity
___ Pain comes and goes and is very mild.
___The pain is mild and does not vary much.
___The pain comes and goes and is moderate.
___The pain is moderate and does not vary much
___The pain comes and goes and is very severe.
___The pain is severe and does not vary much.

Section 2 – Personal Care (washing, dressing, etc)
___I don't change my way of washing or dressing to avoid pain.
___I do not normally change my way of washing or dressing even though it causes some pain.
___Washing and dressing increase the pain but I manage not to change my way of doing it.
increasing pain.
___Washing and dressing increase the pain and I find it necessary to change my way of doing it.
___Because of the pain I am unable to do some washing and dressing without help.

Section 3 –Lifting
___I can lift heavy weight without extra pain.
___I can lift heavy weight but it causes extra pain.
___I cannot lift heavy weight off the floor, but I can manage if conveniently positioned, like on a table.
___I cannot lift heavy weight, but I can manage light to medium weights, if conveniently positioned.
___I cannot lift any weight due to back pain.

Section 4 – Sitting
___I can sit in any chair as long as I like.
___I can only sit in my favorite chair as long as I like.
___I cannot sit more than 1 hour because of back pain.
___I cannot sit more than ½ hour because of back pain.

Section 5 – Standing
___I can stand as long as I want without pain
___I have some pain when standing but it does not increase time.
___I cannot stand longer than 1 hour without increasing pain.
___I cannot stand longer than ½ hour without increasing pain.
___I cannot stand longer than ¼ hour without increasing pain.
___I cannot stand longer than 10 minute without increasing pain.
___I avoid standing because it increases pain right away.

Section 6 – Sleeping
___ I get no pain in bed.
___I get pain in bed but it does not prevent me from sleep
___My normal nights sleep is reduced by ¼ due to pain.
___My normal nights sleep is reduced by ½ due to pain.
___My normal nights sleep is reduced by ¾ due to pain.
___Pain prevents me from sleeping at all.

Section 7 - Walking
___I have no pain when walking.
___I have some pain when walking but it does not increase distance.
___I cannot walk more than1 mile without increasing pain.
___I cannot walk more than ½ miles without

___ I cannot walk more than ¼ miles without increasing pain.
___I cannot walk at all without increasing pain.

Section 8 – Social Life
___My social life is normal and gives me no extra pain.
___My social life is normal but increases the degree of pain.
___Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.)
___Pain has restricted my social life so I don't go out often.
___Pain has restricted my social life to my home.
___I have hardly any social life because of the pain.

Section 9 – Traveling
___I get no pain while traveling.
___I get some pain while traveling but none of my usual forms Of travel make it any worse.
___I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
___I get extra pain while traveling that compels me to seek alternative forms of travel.
___Pain restricts most forms of traveling.
___Pain prevents all forms of travel except while lying down.

Section 10 – Changes in the Degree of Pain
___My pain is rapidly getting better
___My pain fluctuates but overall is definitely getting better.
___My pain seems to be better but improvement is slow.
___My pain is neither getting better or worse.
___My pain is gradually worsening.
___My pain is rapidly worsening.

OVERALL PAIN SCALE (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

_____ _____ _____
Patient Name (Print) Patient Signature Date

For Office Use Only

_____ x 2 = _____ _____
Total Points Disability Percentage Rating Scale

Irrevocable Doctor's Lien and Assignment of Right to Recovery

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctors on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the _____ day of _____, 20 _____, to the full extent of the cost and treatment provided or to be provided me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect the Clinic. I hereby further give, grant, and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the Clinic.

I fully understand that I am directly and full responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration for the Clinic's waiting for payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. In any case, if my balance with the Clinic reaches $1000 and no PIP benefits are available, I understand I may be required to start paying for subsequent services rendered. The Clinic may also bring a case of action against my attorney(s) for failing to honor this binding and irrevocable agreement between the Clinic and me. I further understand and agree that the Clinic is not responsible for paying any of my attorney's fees and the Clinic does not agree to pay my attorney(s) or any attorney fees for honoring this agreement between the Clinic and me.

I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANTY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN.

Print Patient Name : _____

Patient or Guardian Signature: _____ Date: _____

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time toward that end. Therefore, we would like to inform you of our financial policy.

- Any estimates for Patient treatment fees, are just an estimate
- Payment is due at the time of your visit
- Nutritional supplements and other supplies must be paid at time of visit
- Cancellation/No Show policy: 24 hour notice is required for all appointment cancellations. A $15.00 fee will be charged to the patient for all late cancellations and no shows.
- As a courtesy we send an appointment reminder, but you are responsible to keep track of your appointment day and time.

Self Pay Patients: When you are paying for services on the day of your visit and we are not billing your insurance company, filling out any type of forms or paperwork or waiting for payment, we offer a bookkeeping discount on some services.

Medical Insurance: As a courtesy to patients, we will bill your primary insurance carrier; however we do not bill secondary companies except for Medicare patients. Please be aware that any insurance quote for coverage is not a guaranty of benefits. Co-payments, deductibles and percentages that are patient responsibility are due at the time of service. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing that payments be made directly to Tracy & Keim Chiropractic, LLC. We reserve the right to refuse to do business with any insurance company that requires completion of forms regarding permission for us to carry out our patient treatment plan.

Personal Injury/Auto Insurance: Regardless of who the responsible party is, a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill but you will not be required to pay as services are rendered. If your balance reaches $800 and your insurer is withholding payment for any reason, you will be required to start paying for services: we do not hold balances over $800.00 we require that you sign a lien form assigning payment to Tracy and Keim Chiropractic, LLC from an insurance company or from an attorney in cases where one has become necessary.

Worker's Compensation: You are not personally responsible for the account unless your claim is partially or totally denied by Worker's Comp. At that point, we can bill your private insurance if you have chiropractic benefits with that company, or we begin collecting from you if no benefits are available.

Medicare: We are non-participating providers but can accept Medicare patients. Medicare only pays toward spinal manipulation related to an incident or injury, and they will send payment to you. You will be required to pay at the time of service for all services or supplies in our office.

Thank you for taking the time to read this policy. If you have any questions, please don't hesitate to ask.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT INFORMED CONSENT FORM

I,_____, (patient name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Tracy & Keim Chiropractic, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain informed consent before starting treatment.

I, _____, consent to examination and to the performance of conservative noninvasive treatments for my condition, by Dr. Sharell Tracy, Dr. Richard Keim, and/or Dr. Megan Wagner. I understand that the procedures may consist of manipulations involving movement of my joints and soft tissues, along with physical therapy modalities, rehabilitative exercises, x-rays, K-laser, electric therapies and nutraceuticals.

Although spinal and extremity manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that, as with any form of therapy, there are possible risks and complications associated with these procedures, which are as follows:

- Soreness: I am aware that like exercise it is common to experience muscle soreness after a few treatments.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- Joint Injuries: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormality is detected, extra caution will be employed.
- Physical Therapy burns: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.
- Strokes: Strokes from chiropractic manipulation are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur one in a million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Tests will be performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, reduced muscle spasm, increased mobility, and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

The information I have provided on these forms is true and correct to the best of my knowledge. I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction and I hereby authorize this office of chiropractic care to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature_____ Date_____ DOB _____

Doctor/Witness Signature_____ Date_____