Chiropractic Neurology & Wellness Center

New Patient Personal Injury/MVA Intake Form

PLEASE PRINT CLEARLY

Todays Date: ____________________ Date of Birth: ______ I ______ I ______ (MONTH DAY YEAR) Age: ________ Gender: ______________

Legal Name: ____

Preferred Name: ______________________________ Social Security Number: ______________

Address: ____

City: ______________________________ State: ______ Zip: ____________

Phone: __________________ Cell: __________________ E-mail: __________________

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married / Spouse's Name: ______________

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student / School Name: ______________

Occupation: ____

Employer: ______________________________ Work Phone: ______________

Employer Address: ______________________ City: ____________ State: ______ Zip: __________

Emergency Contact: ______________________________ Phone: ______________

Who referred you to our office? ____

Accident Information

Date of Accident: ____________________ Time of Accident: ________________ ☐ A.M ☐ P.M.

Your Vehicle: Year __________ Make ________________ Model ________________ Speed ________MPH

Other Vehicle: Year __________ Make ________________ Model ________________ Speed ________MPH

Accident Type: ☐ Rear ended ☐ Head-on ☐ Broad-sided

Damage to your vehicle $____________________ Damage to other vehicle $____________________

Please describe the accident: ____

____

____

____

Were you the… ☐ Driver ☐ Passenger If you were the passenger, where were you sitting? ☐ Front Seat ☐ Back Seat

Were you wearing your seat belt? ☐ Yes ☐ No Were you aware of the impending collision? ☐ Yes ☐ No

Did you have time to brace for impact? ☐ Yes ☐ No

Did your strike any part of your body on the interior of the car? ☐ Yes ☐ No If Yes, please explain: ______________

____

____

Did you experience ... ☐ Shock ☐ Loss of Consciousness ☐ Other: ______________

____

____

Did the airbag(s) deploy in the vehicle? ☐ Yes ☐ No Road conditions? ☐ Dry ☐ Wet ☐ Icy ☐ Snow

Weather conditions? ☐ Sunny ☐ Light rain ☐ Cloudy ☐ Heavy rain ☐ Foggy ☐ Snowing

Was an ambulance sent to the scene? ☐ Yes ☐ No Were you treated at the scene? ☐ Yes ☐ No

Were you transported to a Hospital? ☐ Yes ☐ No Did you go to the Hospital on your own? ☐ Yes ☐ No

Were you treated at the Hospital? ☐ Yes ☐ No

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Have you received any of the following tests to date? ☐ X-rays ☐ MRI ☐ CT scan ☐ Labs ☐ EMG
☐ Nerve Conduction Velocity Tests ☐ Other: ____________

Have you seen any other Doctors, outside of the hospital since the accident? ☐ Yes ☐ No

Names of Doctors, Chiropractors, Physical Therapists, Acupuncturists, and Massage Therapists you have seen:

____

____

What was your emotional and physical state immediately following the accident: ____________

____

____

What was your emotional and physical state the first few days after the accident: ____________

____

____

Current Symptoms

Please list **ALL** your areas of complaint below:

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

My complaints are made worse by: ____________

____

My complaints are made better by: ____________

____

My pain is…. ☐ Dull ☐ Sharp/Stabbing ☐ Burning ☐ Electrical ☐ Linear ☐ Broad-based

My pain is…. ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

My symptoms are worse … ☐ All day ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night

My symptoms are best … ☐ All day ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night

☐ There is radiating pain into (area): ____________

☐ There is tingling/numbness into (area): ____________

Please rate your average pain level on a scale of 0-10, with “0” being no pain, and “10” being severe pain ______

How do the following activities of daily living affect your symptoms?

	No Change	Relieves	Increases	Duration
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Looking Up	☐	☐	☐	☐
Looking Down	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

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Current Symptoms, contd.

Please mark each that applies to your daily activities:
☐ I have difficulty climbing stairs
☐ I stay at home most of the time due to my symptoms
☐ I change position frequently to try and get comfortable
☐ I walk more slowly than usual because of the symptoms
☐ I don't do jobs around the house because of the pain
☐ I have to use handrails to get up stairs, etc.
☐ I have to lie down frequently due to the pain
☐ I have to hold onto something to sit into or stand up from a chair
☐ I have to get other people to do things for me
☐ I have difficulty getting dressed due to the problem
☐ I can only stand for short periods due to the pain
☐ I have difficulty bending or kneeling due to the pain
☐ I have difficulty turning over in bed due to the problem
☐ I can only walk short distances because of the problem
☐ I have difficulty sleeping because of the problem
☐ I have to get dressed with someone's help
☐ I have to sit most of the day because of the problem
☐ I am more irritable because of the problem
☐ I stay in bed most of the day because of the problem

How is your pain now compared to when the pain first started?

☐ Much improved ☐ Much worse ☐ A little worse ☐ Somewhat better ☐ No change

What are the recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent? ____
____
____
____

How often do you have to stop activities and sit or lie down to control your symptoms?

☐ Several times per day ☐ Occasionally ☐ Approximately once per day ☐ Never ☐ All Day

List your hobbies and exercise activities: ____
____
____
____

Have you lost time from work due to injuries sustained from the accident? ☐ Yes ☐ No

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Supplements
Please list the supplements/vitamins you currently take:

	Supplement	Dose	Frequency	Start Date	Reason For Use
1.					
2.					
3.					
4.					
5.					
6.					

Medications
Please list the prescribed and over-the-counter medications you currently take:

	Medication	Dose	Frequency	Start Date	Reason For Use
1.					
2.					
3.					
4.					
5.					
6.					

Surgeries – Check box if yes and provide date of surgery.

☐ Appendectomy ______________________________

☐ Gall Bladder ______________________________

☐ Tonsillectomy ______________________________

☐ Joint Replacement ______________________________

☐ Angioplasty or Stent ______________________________

☐ Hysterectomy +/- Ovaries ______________________________

☐ Hernia ______________________________

☐ Dental Surgery ______________________________

☐ Heart Surgery ______________________________

☐ Pacemaker ______________________________

☐ Other: ______________________________

Please list and date your significant infections, traumas, and accidents.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Have you been DIAGNOSED with any of the following diseases? Check box if yes and provide date of diagnosis.

Gastrointestinal

☐ Irritable Bowel Syndrome ______________________

☐ Crohn's Disease ______________________

☐ Gastritis or Peptic Ulcer ______________________

☐ Celiac Disease ______________________

☐ Inflammatory Bowel Disease ______________________

☐ Ulcerative Colitis ______________________

☐ GERD (reflux) ______________________

☐ Other: ______________________

☐ Wilderness Camping? ☐ Yes ☐ No Where? ______________________

☐ Foreign Travel? ☐ Yes ☐ No Where? ______________________

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Have you been DIAGNOSED with any of the following diseases? Check box if yes and provide date of diagnosis.

Cardiovascular

☐ Heart Attack ______________________
☐ Stroke ______________________
☐ Elevated Cholesterol ______________________
☐ Elevated Triglycerides ______________________
☐ Arrhythmia ______________________
☐ High Blood Pressure ______________________
☐ Rheumatic Fever ______________________
☐ Mitral Valve Prolapse ______________________
☐ Anemia ______________________
☐ Other: ____

Cancer

☐ Asthma ______________________
☐ Breast Cancer ______________________
☐ Colon ______________________
☐ Ovarian Cancer ______________________
☐ Prostate ______________________
☐ Skin Cancer ______________________
☐ Other: ____

Metabolic/Endocrine

☐ Type I Diabetes ______________________
☐ Type II Diabetes ______________________
☐ Hypoglycemia______________________
☐ Metabolic Syndrome ______________________
☐ Insulin resistance or Pre-Diabetic ______________
☐ Hypothyroidism (low thyroid) ______________
☐ Hyperthyroidism (overactive thyroid ______________
☐ Hoshimoto's Autoimmune Thyroid ______________
☐ Polycystic Ovarian Syndrome______________
☐ Infertility ______________________
☐ Weight Loss ______________________
☐ Weight Gain ______________________
☐ Frequent Weight Fluctuations______________
☐ Bulimia ______________________
☐ Anorexia ______________________
☐ Binge Eating Disorder______________
☐ Night Eating Disorder ______________
☐ Eating Disorder (Non-Specific) ______________
☐ Other: ____

Genital and Urinary Systems

☐ Kidney Stones ______________________
☐ Gout ______________________
☐ Interstitial Cystitis ______________________
☐ Frequent Urinary Tract Infections ______________
☐ Frequent Yeast Infections ______________
☐ Erectile Dysfunction/Sexual Dysfunction ______________
☐ Other: ____

Inflammatory/Autoimmune

☐ Chronic Fatigue Syndrome______________
☐ Autoimmune Disease ______________________
☐ Rheumatoid Arthritis ______________________
☐ Lupus (SLE)______________________
☐ Severe Infectious ______________________
☐ Poor Immune /Function ______________________
☐ Frequent Infections ______________________
☐ Food Allergies ______________________
☐ Environmental Allergies ______________________
☐ Multiple Chemical Sensitivities ______________
☐ Other: ____

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Have you been DIAGNOSED with any of the following diseases? Check box if yes and provide date of diagnosis.

Respiratory Diseases

☐ Asthma ____________________
☐ Chronic Sinusitis ____________________
☐ Bronchitis ____________________
☐ Emphysema ____________________
☐ Pneumonia ____________________
☐ Tuberculosis ____________________
☐ Sleep Apnea ____________________
☐ Other: ____________________

Skin Diseases

☐ Eczema ____________________
☐ Psoriasis ____________________
☐ Acne ____________________
☐ Melanoma ____________________
☐ Skin Cancer ____________________
☐ Other: ____________________

Neurologic/Mood

☐ Depression ____________________
☐ Anxiety ____________________
☐ Bipolar Disease ____________________
☐ Schizophrenia ____________________
☐ Headaches ____________________
☐ Migraines ____________________
☐ ADD/ADHD ____________________
☐ Autism ____________________
☐ Mild Cognitive Impairment ____________________
☐ Memory Problems ____________________
☐ Parkinson's Disease ____________________
☐ Multiple Sclerosis ____________________
☐ ALS ____________________
☐ Seizures ____________________
☐ Other: ____________________

Musculoskeletal/Pain

☐ Osteoarthritis ____________________
☐ Fibromyalgia ____________________
☐ Chronic Pain ____________________
☐ Other: ____________________

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Family Medical History

Check all that apply	Mother	Father	Brother	Sister	Children	Mother's Parents	Father's Parents	Aunts & Uncles
Ages						NA	NA	NA
Cancers	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hoshimoto's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis/Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Other								
Other								

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Patient Health Information

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chiropractic Neurology & Wellness Center (CNWC) to use their patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CNWB to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature:____ Date: ____________________________

Patient's Name:____
PLEASE PRINT

Chiropractic Neurology & Wellness Center

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications that may arise during a Chiropractic adjustment. Those complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costrovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read _________(initial) or have had read to me _________(initial) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Chiropractic Neurology & Wellness Center	Name of Doctor Treating this Patient
618 Frederick St., Santa Cruz, CA 95062	James M. Cartwright, D.C., D.A.C.N.B.
831-460-9200	www.cartwrightwellness.com

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_______________________________________ _______________________
Printed Name of Patient Date

_______________________________________ _______________________
Signature of Patient Date

_______________________________________ _______________________
Signature of Patient's Representative Date

Chiropractic Neurology & Wellness Center

FINANCIAL POLICY FOR PERSONAL INJURY

All fees are based on individual services rendered, and may vary from visit to visit depending upon the doctor's specific recommendations.

NOTE: Unless all proper claim and insurance information is provided, the patient will be responsible for payment of care received after the first visit until the necessary information can be validated.

We require a 48-hour notice for ALL cancellations.
You will be charged the full amount of your scheduled visit if changes are made within this 48-hour limit. We require that all patients store a credit card on file for any missed appointment fees; however no other charges will be made unless the account becomes past due for a period of 30 days or more.

INSURANCE/MED-PAY:
You will need to provide our office with correct and current auto insurance information, including a claim number, adjustor's name, and phone number.

NON-INSURED/LIEN:
If you do not have auto insurance that will cover your treatments, it is up to the doctor to determine whether he is willing to place the patient on a lien. Once an attorney has been contracted, we require the patient to submit two signed copies of our "Notice of Doctor's Lien."

By signing this form, I authorized Chiropractic Neurology & Wellness Center to receive lien payment from all liable insurance companies, attorneys, or myself for all monies due on my account. _____ initial

MEDICARE**
****If you have been involved in a motor vehicle accident, we CANNOT bill Medicare for services related to your accident.**

I acknowledge that in the event that there is an outstanding balance, which fails to be cured within 120 days (four months) of being released from active care, I am responsible for paying the balance due, or setting up a payment plan.

I agree to the terms of this agreement.

Signature:____ Date:____________________

Printed name:_____________________________________

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INSURANCE / ATTORNEY INFORMATION

Patient Name: ______________________________

Your Insurance Company
Company Name: ______________________________

Policy Number/Claim Number: ______________________________

Agent/Adjuster: ______________________________

Insurance Company Address: ______________________________

City: ______________________________ State: ________ Zip: ____________

Phone/Ext: ________________ Fax: ________________ Email: ________________

Do you have Medical Pay on your policy? ☐ Yes ☐ No

Insurance Company of Person at Fault
Company Name: ______________________________

Policy Number/Claim Number: ______________________________

Agent/Adjuster: ______________________________

Insurance Company Address: ______________________________

City: ______________________________ State: ________ Zip: ____________

Phone/Ext: ________________ Fax: ________________ Email: ________________

Attorney Information
Have you hired an attorney? ☐ Yes ☐ No

Attorney's Name: ______________________________

Attorney's Address: ______________________________

City: ______________________________ State: ________ Zip: ____________

Phone/Ext: ________________ Fax: ________________ Email: ________________

Please note: If you have medical coverage, it is our policy that we will bill the insurance company for charges incurred in our office. However, there may be some charges that they ***may not*** pay for, such as supplementation, and/or exercise equipment that the doctor feels necessary to your treatment and recovery. Should this be the case, it will be your responsibility to pay for all denied charges; you may be able to be reimbursed for these payments when your case is settled with the third party insurance company.

____________________________________ __________________

Signature of Patient Date

____________________________________ __________________

Printed Name of patient Date