VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

– OVER –

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

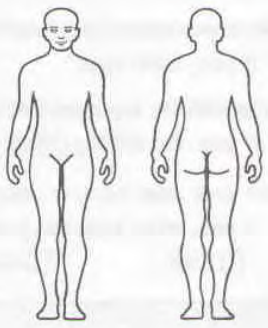
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that **Gordon Chiropractic's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Gordon Chiropractic's** Notice of Privacy Practices prior to signing this document. Gordon Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Gordon Chiropractic**. The Notice of Privacy Practices for Gordon Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **Gordon Chiropractic's** duties with respect to my protected health information.

Gordon Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company.

_____ _____
Patient Signature Date

Permission to Administer Treatment

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

_____ _____
Patient Signature Date

To help expedite processing of your insurance claims, we ask that you answer the following questions concerning the nature and onset of your symptoms.

1. Is the reason for seeing the doctor due to an automobile or work related injury? [ ] YES [ ] NO

2. Are you currently under care by any doctor for an automobile or work related injury? [ ] YES [ ] NO

The above information is true to the best of my knowledge. My signature below is an authorization to release this information to my insurance carrier.

_____ _____
Patient Signature Date

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____
Patient Signature Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

_____ _____
Patient Signature Date

7887 Cooley Lake Road, West Bloomfield Township, MI 48324 | (888) 763-6152

☐Complete ☐DXs entered File #________________

ELECTRONIC HEALTH RECORDS HISTORY & EXAMINATION

Patient Name ____ Date ____________________

1. Demographics

A. Ethnicity ____ non-Hispanic ____ Hispanic

B. Preferred language ____ English ____ Spanish ____ Other

C. Race ____ White/Caucasian ____ African American ____ Native American

____ Hawaiian/Pacific Isl. ____ Other ________________________

____ Don't know/Prefer not to say

2. ***Would you like an email reminder of upcoming appointments or phone call?*** ________________

Email Address ____

****__________(please initial) **I hereby give my consent to have my health records available to me via a secure, web-based portal.** (you will be given a password to be able to access records)

3. ***Are you taking any medications (including Vitamins)*** ______ YES ______ NO

If Yes, please list medications (*be specific*) you are currently taking along with dosage.

***** if you have a medication list, we can copy it for you instead.**

____ **dosage** ____________________

____ **dosage** ____________________

____ **dosage** ____________________

If additional room is needed please continue on back of page or provide a list for copying.

4. ***Are you allergic to any medications?*** ______ YES ______ NO

If yes, please list below along with reaction/problem experienced

____ ______________________________________

____ ______________________________________

5. ***Do you smoke now?*** ____ YES ____ NO ***Have you ever been a smoker?*** ____ YES ____ NO

Do you use any other form of tobacco (cigars, chew)? ____ YES ____ NO

If a current tobacco user, please complete the following:

What type _________________________________ How much per day __________________________

Have you tried to quit? ____ YES ____ NO What methods did you use? ________________________

OFFICE USE ONLY

Vital Signs: Height _______ Weight _______ BP _______/_______ Pulse _______

Primary Diagnosis _____________ Header Date __________ Use back for additional space

THE NATURAL WAY
GORDON
CHIROPRACTIC

7887 COOLEY LAKE ROAD, SUITE 120 · WEST BLOOMFIELD, MI 48324
(248) 366-3300 · FAX (248) 366-3396 · gordondc.com

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic examinations, diagnosis, and analysis.

Like all forms of health care, Chiropractic care offers considerable benefits. However, as with all forms of health care, the practice of chiropractic involves some risks to treatment including, but not limited to; fractures, disc injuries, strokes, dislocations, and sprains. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury.

I understand that the doctor will use his hands and/or a mechanical device upon my body during treatment. The doctor will not give any treatment or health care if he/she is aware that such care may be contraindicated (a condition which makes a particular treatment or procedure inadvisable). Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to attention of the Chiropractic Physician.

The Chiropractic Physician provides a specialized, non-duplicating health care service. Our Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a Chiropractic Physician at Oakland Chiropractic Clinic PLC, I am authorizing them to proceed with any treatment and/or adjunct therapies that may be necessary. There has been no promise, implied or otherwise, of a cure for any symptom, disease or conditions as a result of treatment at Oakland Chiropractic Clinic. I have had an opportunity to speak with a Chiropractic Physician at Oakland Chiropractic Clinic. All my questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction and the benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Patient Name (Print)	Patient or Legal Guardian Signature
Relationship to Patient	Date
Witness Signature (Office Staff)	Date