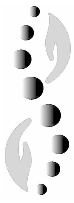

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INTERNAL USE ONLY

___CASE TYPE ___COVERAGE TYPE
___CONDITION TAB ___CLAIM#
___BATCH CLAIM ONLY ___TERM OTHER COVERAGE

MOTOR VEHICLE ACCIDENT INTAKE FORM

1 ACCIDENT INFORMATION

FIRST NAME ____________ LAST NAME ____________

DATE OF ACCIDENT ____________ TIME ________ ◯ AM ◯ PM LOCATION ____________

Were you: ◯ DRIVER ◯ PASSENGER ◯ PEDESTRIAN

Were you struck from: ◯ BEHIND ◯ RIGHT SIDE ◯ LEFT SIDE ◯ FRONT ◯ PARKED

Did your car strike others involved? ◯ YES ◯ NO ◯ UNDETERMINED

Did the other car strike yours? ◯ YES ◯ NO ◯ UNDETERMINED

As a result of the accident, were traffic citations issued to you? ◯ YES ◯ NO

Please describe the circumstances of the accident in detail:

____

____

2 ACCIDENT SYMPTOMS

Did you require post-accident hospitalizations or an emergency room visit? ◯ YES ◯ NO

Check symptoms you have noticed since the accident.

◯ Headaches	◯ Sleeping Problems	◯ Lights Bother Eyes	◯ Diarrhea
◯ Neck Pain	◯ Head Too Heavy	◯ Loss of Memory	◯ Cold Feet
◯ Neck Stiff	◯ Pins & Needles in Arms	◯ Ears Ringing	◯ Cold Hands
◯ Dizziness	◯ Pins & Needles in Legs	◯ Face Flushed	◯ Stomach Upset
◯ Back Pain	◯ Numbness in Fingers	◯ Buzzing in Ears	◯ Constipation
◯ Nervousness	◯ Numbness in Toes	◯ Loss of Balance	◯ Cold Sweats
◯ Tension	◯ Shortness of Breath	◯ Fainting	◯ Fever
◯ Irritability	◯ Fatigue	◯ Loss of Smell	◯ Other
◯ Chest Pain	◯ Depression	◯ Loss of Taste	

3 INSURANCE INFORMATION

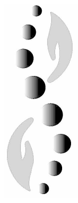
Personal Policy:	**Responsible Party:**
AUTO INSURANCE COMPANY	AUTO INSURANCE COMPANY
ADDRESS	ADDRESS
POLICY#	POLICY#
AGENT'S NAME | PHONE	AGENT'S NAME | PHONE
CLAIM#	CLAIM#

Do you have an attorney that has advised you in this case? ◯ YES ◯ NO

If yes, attorney's name & address ____________________

New Beginnings Chiropractic has my permission to share information with appropriate parties in order to process claims.

PATIENT/PARENT/GUARDIAN NAME (PRINT) ____________ PATIENT/PARENT/GUARDIAN SIGNATURE ____________ DATE ________



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ADULT
PATIENT INFORMATION

INSURANCE INFORMATION: Please present your insurance card(s) at time of service. If you have primary **AND** secondary insurance please inform the front desk, so there is no discrepancy with your claims.

1 PATIENT DEMOGRAPHICS

FIRST NAME ______ LAST NAME ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

HOME PHONE ______ CELL PHONE ______ GENDER ◯ M ◯ F

EMAIL *This will be used to email receipts, for future newsletter mailings or massage specials only. It will not be solicited.*

BIRTH DATE MM|DD|YYYY ______ AGE ______

IS YOUR VISIT TODAY DUE TO A: ◯ CAR ACCIDENT ◯ WORKERS COMPENSATION

STATUS ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ OTHER ______

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯ GOOGLE/ OTHER ______

◯ EXISTING PATIENT ______ ◯ ANOTHER PROVIDER ______

2 EMERGENCY CONTACT

FIRST NAME ______ LAST NAME ______

RELATIONSHIP TO PATIENT ______ PHONE ______

YOUR PRIMARY DOCTOR ______ PHONE ______

3 EMPLOYMENT INFO

EMPLOYMENT STATUS ◯ FULL-TIME ◯ SELF-EMPLOYED ◯ STUDENT ◯ PART-TIME ◯ UNEMPLOYED ◯ RETIRED

EMPLOYER ______ OCCUPATION ______ WORK PHONE ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

You may be asked to sign a Patient Authorization to Release Information, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

4 INSURANCE INFORMATION

PATIENT NAME ON INSURANCE CARD (PRINT) ____ DATE POLICY ACTIVE ____

NAME OF INSURANCE CARRIER ____

Do you have insurance? ◯ Yes ◯ No

POLICY NUMBER ____ GROUP NUMBER ____

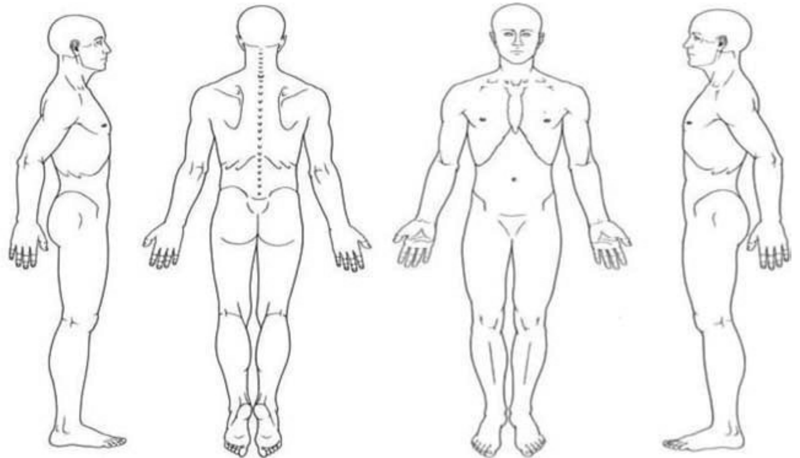
1. **Describe your symptoms *presently:*** ____

When & how did your symptoms start? ____

What makes it better/worse? ____

2. **How often do you experience your symptoms?**
   - ◯ Constantly (76-100% of the day)
   - ◯ Frequently (51-75% of the day)
   - ◯ Occasionally (26-50% of the day)
   - ◯ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. **What describes the nature of your symptoms?**
   - ◯ Sharp ◯ Shooting ◯ Radiating
   - ◯ Dull ache ◯ Burning
   - ◯ Numb ◯ Tingling

4. **What describes the nature of your symptoms?**
   - ◯ Getting Better
   - ◯ Not Changing
   - ◯ Getting Worse

5. **During the past 4 weeks:**

   Indicate the average intensity of your symptoms

   NONE 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

   How much has pain interfered with your normal schedule? (Including work and home)

   ◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

   How much of the time has your condition interfered with your social activities?

   ◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

6. **In general would you say your overall health is right now.**

   ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

7. **Who have you seen for your symptoms?** ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other

   What treatment did you receive and when? ____

   What tests have you had for your symptoms? ◯ Xrays DATE ____ ◯ CT Scan DATE ____

   ◯ MRI DATE ____ ◯ Other DATE ____

8. **Have you had similar symptoms in the past?** ◯ Yes ◯ No

   If you have received treatment in the past for the same or similar symptoms, who did you see? ◯ This Office ◯ Medical Doctor ◯ Other ◯ Chiropractor ◯ Physical Therapist

9. **Is your pain:** ◯ worse in morning ◯ worse at night ◯ worse with cough/sneeze ◯ disrupting sleep

   Have you ever been to a chiropractor before? ◯ Yes ◯ No

If YES, when was your last adjustment: DATE ____ Were your goals met with this chiro? ◯ Yes ◯ No

PATIENT SIGNATURE ____ DATE ____

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PATIENT NAME (PRINT) ____________________ DATE ____________

What Activities of Daily Living does your current condition effect (self-care, driving, stairs etc)? ____________________

What type of regular exercise do you perform? ○ None ____________________

What is your height and weight? Height [ ] FEET [ ] INCHES Weight [ ] lbs

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

PAST	PRESENT	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular In-coordination
○	○	Visual Disturbances
○	○	Dizziness

PAST	PRESENT	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

PAST	PRESENT	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco
○	○	Drug/Alcohol Dependence
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	Digestive Issues
		Females Only
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy/How many?____
		Other Health Issues list below:
○	○	____________
○	○	____________

Do you have any **allergies**? (to food/medication/seasonal)? ____________________

Indicate if any immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ Other ____________

List ALL prescriptions, over-the-counter medications, and nutritional supplements you are taking:

____________ ____________ ____________

____________ ____________ ____________

List ALL surguries/hospitalization/conditions/car accidents/sports injuries (even if you got no treatments for them)

____________ ____________ ____________

____________ ____________ ____________

PATIENT SIGNATURE ____________________ DATE ____________

Doctor's Additional Comments

DOCTOR SIGNATURE ____________________ DATE ____________

making your health a priority

*PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS:

○ TEXT ○ EMAIL ○ BOTH

FINANCIAL POLICY

1. Please verify your chiropractic benefits with your health insurance company. When our staff calls on your benefits they only give us an outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
2. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
3. If your insurance requires a referral from another provider, we will require information of the referral to process your insurance with in–network benefits. Until this information is provided to us, we require you to pay all co–pays, deductibles and/or co–insurance relating to out–of–network benefits. Any over payments to your account will be reimbursed to you after insurance pays their portion.
4. If your insurance carrier has not paid your claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all charges.
5. I hereby authorize payment to be made directly to New Beginnings Chiropractic LLC for all benefits which may be payable under a Healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to New Beginnings LLC for any and all services I receive at this office.

I have read and understand and agree to abide by the information stated above as it applies to my coverage.

PATIENT NAME (PRINT)	PATIENT SIGNATURE	DATE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT & HIPAA NOTICE

I hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at New Beginnings Chiropractic, and/or other licensed doctor of chiropractic who now or in the future render treatment to me while employed by or associated with New Beginnings Chiropractic. I have had an opportunity to discuss with the physician and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, muscle sprain/strain, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

PATIENT NAME (PRINT)	PATIENT SIGNATURE	DATE

I consent to the use or disclosure of my protected health information by New Beginnings Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of New Beginnings Chiropractic. I understand that analysis, diagnosis or treatment of me by New Beginnings Chiropractic may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of this practice. New Beginnings Chiropractic is not required to agree to the restrictions that I may request. However, if New Beginnings agrees to a restriction that I request, the restriction is binding on New Beginnings Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that New Beginnings Chiropractic has taken action in reliance on the consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past,present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. A full copy of HIPAA policies are available upon request.

PATIENT NAME (PRINT)	PATIENT SIGNATURE	DATE

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don’t get dressed, I was with difficulty and stay in bed

3. LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. 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
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

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, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score ______