PATIENT INTAKE FORM | Auto Accident

GRAFFEO ACCIDENT & INJURY CLINIC
Joseph Graffeo, DC, PC
16248 NE Glisan St • Portland, OR 97230

Date: ___________________

ABOUT YOU

First Name ___________________ Middle Name ___________________

Last Name ___________________ Email Address ___________________

Street Address ___________________

City ___________________ State __________ Zip ___________

Date of Birth: _____ / _____ / ________ Age: ________ Gender: Male Female

Marital Status: Single Married Divorced Separated Widowed Other

Number of Children: ________ Spouse's Name: ___________________

Height: ______ ' ______ " Weight: ___________ lbs Dominant Hand: Right Left

Cell Phone: ____-____-______ Home Phone: ____-____-______ Work Phone: ____-____-______

Employment Status:
- Full-time *(20-40+ hours/week)*
- Part-time *(1-19 hours/week)*
- Permanently fully disabled
- Retired
- Student
- Permanently partially disabled
- Homemaker
- Unemployed

Occupation: ___________________ Employer: ___________________

EMERGENCY CONTACT INFORMATION

Name ___________________

Phone Number: ____-____-______ Relation to you: ___________________

REFERRAL INFORMATION

Primary Care Doctor: ___________________ Phone: ____-____-______

Are you working with an attorney? Yes No Atty Name: ___________________

How did you hear about us? Family or Friend (enter name): ___________________

Advertisement Internet Sign Other: ___________________

INSURANCE INFORMATION

YOUR VEHICLE

Enter the insurance information for **the car you were in.**

Insurance Name ___________________ Phone: ____-____-______

Name of Person who owns car: ___________________ Phone: ____-____-______

Have you reported this accident to that insurance company? Yes No

Do you have a claim number? If so, enter: ___________________

YOUR PERSONAL AUTO INSURANCE *(if different)*

Do you have **your own** auto insurance? Yes No

Insurance Name ___________________ Phone: ____-____-______

INSURANCE INFORMATION
continued

THE OTHER VEHICLE

Enter the insurance information for the **other car** in this accident, if known:

Insurance Name ______________________________ Phone: ____-____-______

Name of Person who owns car: ______________________________ Phone: ____-____-______

Have you reported this accident to that insurance company? Yes No

Do you have a claim number? If so, enter: ______________________________

PERSONAL INJURY - AUTO ACCIDENT HISTORY

What type of accident caused your injury?

Two or more automobiles
Injured by a vehicle as a pedestrian
Motorcycle or bicycle and no other vehicle
An automobile and a motorcycle or bicycle
Other *(describe)*: ______________________________

When did the accident happen? **Date:** ____ / ____ / ______ **Time:** _________ AM PM

Where did the accident happen?
Enter the location of your accident

City, Streets: ______________________________

____

Describe in detail how the accident happened:

____
____
____
____
____
____
____
____
____
____
____

DRAW THE ACCIDENT

Where in the vehicle were you seated at the time of the accident?

Driver's Seat Front Passenger
Rear Passenger on: Left Middle Right
If Child, in: Booster Seat Infant/Child Seat

Which part of your vehicle was damaged?
Choose all that apply

Front - head on Front left Front right
Rear end - center Rear left Rear right
Left side *(driver's side)* Other: ____________________
Right side *(passenger's side)*

PERSONAL INJURY - AUTO ACCIDENT HISTORY
continued

Were you wearing a seatbelt?	Yes	No	
In what direction were you looking at the time of the accident?	Straight Ahead	Ahead but cannot be certain	
	To the left	To the right	
	Over left shoulder	Over right shoulder	
	Down	Other: ____________________	
Where were your hands at the time of the accident?	On the steering wheel	On the gear shift	
	Other: ____		
Did you receive an injury to the head?	Yes	No	
Did you lose consciousness?	Yes	No	
If so, how long were you unconscious?	Less than 30 minutes	More than 30 minutes	
Did the airbags deploy?	Yes	No	
Did you come in contact with anything at the time of the collision? *Choose all that apply*	Nothing	Door	Window
	Air Bags	Headrest	Steering Wheel
	Seat	Armrest	Dashboard
	Flying object(s) inside vehicle	*Describe:* ____________	
	Other: ____		
Was your vehicle towed from the scene?	Yes	No	
Did police arrive at the scene?	Yes	No	
Was an accident report taken?	Yes	No	***If yes, please give us a copy.***
Did Emergency Medical Services arrive at the scene?	Yes	No	
How did you leave the scene of the accident?	Transported by Emergency Services to hospital/ER		
	Driven to hospital/ER by family or friend		
	Drove home in my own car		
	Arranged for a ride home		
	Continued on to my original destination		
Have you seen other doctors for this accident?	No	Yes: *Doctor's Name:* ____________________	
	Visit Date/s: ____		
If you delayed seeking treatment for more than two weeks, mark or enter the reason for your delay.	I expected the symptoms to stop		
	I had to take care of my family		
	I didn't know I could see a doctor		
	I had to work		
	I didn't have a car		
	Other: ________________________________		
What did you do for your symptoms during the delay?	Nothing	Rested more	
	Took pain medication	Got massages	
	Name of medication/s: ________________________	Other: ________________	

MEDICAL HISTORY

Have you had in the past or do you have now any of the following health issues?
Mark all that apply. Enter any "Other" conditions not shown. If none apply, mark the box below.

CONDITIONS of the HEAD, EYES, EARS, NOSE or THROAT

Sinus Trouble
Visual Disturbances
Pain in Jaw Joints
Hearing Difficulty

CANCER

Prior Cancer
Leukemia
Current Cancer
Night Sweats

NEUROLOGICAL CONDITIONS *(Nerve-related)*

Migraines
Fainting or Dizziness
Stroke or TIA
Epilepsy or Seizures

PULMONARY CONDITIONS *(Lung-related)*

Asthma
Breathing Problems
Lung Disease
Emphysema/COPD

ENDOCRINE CONDITIONS *(Glandular/Hormonal-related)*

Diabetes
Thyroid Disease
Liver Disease
Hypoglycemia

CARDIO-VASCULAR CONDITIONS *(Heart-related)*

Hemophilia
Heart Disease
Anemia
High Blood Pressure

MUSCULOSKELETAL CONDITIONS *(Bone/Muscle-related)*

Osteoporosis
Arthritis/Gout
Artificial Joint
Fibromyalgia

RENAL CONDITIONS *(Kidney-related)*

Kidney Disease
Dialysis
Kidney stones
Bladder Infections

GASTROENTEROLOGICAL CONDITIONS *(Stomach-related)*

Recent Weight Loss
Stomach/Intestinal Disease
Recent Weight Gain
Ulcers

DERMATOLOGICAL CONDITIONS *(Skin-related)*

Significant rashes
Psoriatic disorders

ALLERGIES OR SENSITIVITIES

Describe: ______________________________

PSYCHOLOGICAL CONDITIONS

Describe: ______________________________

OTHER CONDITION: ______________________ **I HAVE NONE OF THESE CONDITIONS.**

Are you presently taking ANY medications? No Yes: *What are you taking?* ______________________

____

Have you ever had any MAJOR surgeries? No Yes: *Type of Surgery:* ______________________

Reason: ______________________ *Surgery Date/s:* ______________

Have you been in the hospital in the past FIVE years? No Yes: *What Hospital?* ______________________

Reason: ______________________ *Date/s:* ______________

Have you had any prior AUTO ACCIDENTS? No Yes: *Date/s of Accident/s:* ______________________

Were you injured? No Yes: *If Yes, were you treated for this Injury?* No Yes:

Doctor's Name: ______________________ *Visit Date/s:* ______________

MEDICAL HISTORY
continued

Have you had any
<u>other</u> RECENT injuries? No Yes: *Type of Injury:* ____

Date of Injury: __________________ *Were you treated for this Injury?* No Yes:

Doctor's Name: ____ *Visit Date/s:* _____________________

Are you currently treating
with any other doctor? No Yes: *Doctor's Name:* ______________________________________

Reason: ____ *Visit Date/s:* _____________________

ADULT WOMEN'S HEALTH *- for Women Only*

Are you pregnant? Yes No **Are you nursing?** Yes No

What was the date of your last menstrual period?

- Within the past month or currently
- Within the past 1 to 3 months
- Greater than 3 months
- Postmenopausal
- Have not yet begun menstruation
- Prefer not to answer or don't know

FINANCIAL AGREEMENT | Auto Accident

As a courtesy to our patients with a personal injury claim which provides coverage for treatment at our clinic, we will bill the insurance company (or other party) for the services we provide to you. However, accident insurance policies are an arrangement made between an insurance carrier and the patient, and it is still your responsibility to make collection from the insurance company (or other party). While our clinic will bill the insurance company (or other party) on your behalf, the services rendered to you are charged directly to your account, and you are personally responsible for payment.

We will contact the insurance company for information about covered services, but this is not a guarantee that your insurance company will pay for all the services you receive. We must receive payment at the time of service for any amounts we do not expect the insurance company to pay (for example, co-pays, deductibles, and items that are not covered, such as supplements). You are also responsible to pay our clinic promptly for any amount that the insurance company (or other party) fails to pay to us.

INFORMED CONSENT

Chiropractic treatment and physiotherapy (including chiropractic adjustments, manual therapy, therapeutic massage, therapeutic exercise, whole body vibration, cold laser therapy, electrotherapy, and therapeutic nutrition) are highly safe and effective methods of care. Other treatment options for your condition may include: self-administered over-the-counter analgesics; rest; medical care and prescription drugs such as anti-inflammatories, muscle relaxers, or pain-killers; hospitalization; or surgery. While chiropractic care is remarkably safe, as with all types of health care, complications may arise. Although the chance of experiencing any complication is very small, you need to be informed about the potential risks before consenting to treatment. Complications may include soreness, inflammation, sprains, dislocations, or fractures, soft tissue injury, dizziness, or a temporary worsening of your symptoms. More serious complications, such as injuries to the neck arteries, stroke, spinal disc injuries, or spinal fractures are extremely rare. The chance of such injury is estimated to range from one in one million treatments to one in ten million treatments. You are always welcome to ask questions, and we encourage you to participate in your healing process.

ACKNOWLEDGEMENT & CONSENT TO TREATMENT

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic, including the use of my email address for all permissible applications. I authorize this office and its staff to examine and treat my condition as the doctors see fit, and request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible). I authorize and approve treatment by any licensed doctor of chiropractic who now or in the future may be employed by, working with, or associated with the Clinic (or substituting for such doctor or staff member).

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I promise to pay promptly when presented with my bill, and agree to notify you within sixty days if I think that part of the bill is in error. I agree to permit the clinic to apply a Finance Charge of 0.75% per month (annual percent of 9%) on any amount outstanding after 90 days.

Patient Signature	Personal Representative's Signature
Description of Personal Representative's authority to act for the patient.	Personal Representative's Name *(Printed)*
Signature of Physician: ____________________	*Staff Witness:* ____________________