PAIN & REHABILITATION SOLUTIONS

AUTO ACCIDENT INFORMATION SHEET

Patient's Name:_____ Sex: (M)___(F) ___

Home Telephone: _____Cellular Telephone:_____

Patient's Address:_____

City, State, Zip Code:_____

Date of Injury:_____Initial Date:_____

Social Security:_____Date of Birth:_____

Attorney Name:_____

Attorney Phone:_____Attorney Fax:_____

Insurance Name:_____

Insurance Address:_____

City, State, Zip Code:_____

_____

EMPLOYER'S INFORMATION

Employer's Name:_____

Employer's Telephone(s):_____

Address:_____

City, State, Zip Code:_____

12000 Richmond Ave #330
Houston, TX 77082

713-334-0530 Phone * 713-334-0552 Fax
Email: rehab.pain@gmail.com

PAIN & REHABILITATION SOLUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM
You may refuse to sign this acknowledgement but, in refusing
we will not be allowed to process your claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for PAIN AND REHABILITATION SOLUTIONS. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____
Please *print* your name Birth Date and/or Medical Record number

_____ _____
Street Address City, State, Zip Code

Authorize: Release of Protected Health Information To:

PAIN & REHABILITATION SOLUTIONS & _____

12000 RICHMOND AVE. SUITE 330 _____

HOUSTON, TEXAS 77082 _____

Information to Be Released:

___Medical History, Examination, Reports ___Surgical Reports ___Immunization ___X-Ray Reports
___Treatment/Tests ___Allergy Records ___Consultations ___Laboratory Reports
___Prescriptions ___Hospital Records Including Reports ___Entire Record

Purpose for Need of Disclosure: (Check all applicable categories)

___Further Medical Care ___Legal Investigation or Action ___Insurance Eligibility/ Benefits
___Changing Physicians ___Other (Specify) ___Personal

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Patient or Legal Representative **Date**
(If signed by other than patient, state relationship/authority to do so)

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

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PAST MEDICAL HISTORY

Name: _____ DOB: _____ Age: ____ Height: _____ Weight: _____ Date: _____

PCP/Referred By: _____ Pharmacy Name _____ Pharmacy #: _____

Are you claustrophobic? Y N Do you have metal in your body? Y N If female, are you pregnant? Y N

HISTORY OF PRESENT PROBLEM:

1. Location of Pain/Injury: _____ RIGHT / LEFT
2. How Did Symptoms Start: _____ ☐ Work ☐ Motor Vehicle Accident
3. When Did Symptoms Start: _____ ☐ Gradual ☐ Sudden
4. Rate Your Pain: 1 2 3 4 5 6 7 8 9 10
5. Quality of Pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
6. Do you have: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Other: _____
7. What makes your symptoms worse? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Bending ☐Sitting ☐Squatting ☐Kneeling ☐Coughing ☐Sneezing ☐Lying In Bed ☐ Other: _____
8. What makes your symptoms better? ☐Sitting ☐Standing ☐Heat ☐Rest ☐Ice ☐Elevation ☐ Other: _____
9. What medications have you tried for this problem? _____
10. Test you have had: ☐X-Ray ☐MRI ☐CT ☐Bone Scan ☐Nerve Test (EMG/NCV)
11. Have you tried: ☐Injections ☐Brace ☐Physical Therapy ☐Chiropractor ☐Acupuncture

MEDICATIONS: List all medications with dose, to include: prescription, OTC, Herbal and Vitamins

Med: _____ Med: _____

Med: _____ Med: _____

Med: _____ Med: _____

Med: _____ Med: _____

See Attached Sheet

Do you have any DRUG ALLERGIES? ☐ YES ☐ NO

If yes, please list: _____

_____

Have you ever had SURGERY? ☐ YES ☐ NO

If yes, please list: _____

_____

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HIPAA Release of information AUTHORIZATION FORM

I, _____hereby authorize _____ and its affiliates, its employees and agents (collectively _____), to release to _____ **[Insert full name of person/organization]** my personal health information maintained by _____ (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with _____.

I understand that I have a right to revoke this authorization by providing written notice to _____. However, this authorization may not be revoked if _____, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____

Date:_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

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Have you had spinal X-rays, MRI or CT scan?

□No

□Yes, Date(s) and place taken_____

_____

Please check all of the following that apply to you or check:

□ **NONE APPLY**

NO	YES		NO	YES	
□	□	History of recent Infection	□	□	Recent Trauma
□	□	Recent Fever	□	□	Prostrate Problems
□	□	HIV / AIDS	□	□	Frequent Urination
□	□	Diabetes	□	□	Pregnancy, # of Births:_____
□	□	Corticosteroid Use	□	□	Abnormal Weight Gain/Loss
□	□	Birth Control, Type:_____	□	□	Epilepsy / Seizures
□	□	High Blood Pressure	□	□	Visual Disturbances
□	□	Stroke, Date:_____	□	□	History of low/mid back pain
□	□	Dizziness / Fainting	□	□	History of neck pain
□	□	Numbness in Groin / Buttocks	□	□	Arthritis
□	□	Urinary Retention	□	□	History of alcohol use
□	□	Aortic Aneurysm	□	□	History of tobacco use
□	□	Cancer / Tumor	□	□	Surgeries / Medications:____
□	□	Osteoporosis			

_____

_____

Does your family have a history of any of the following?

□ Cancer □ Diabetes □ High Blood Pressure □ Cardiovascular Problems / Strokes

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered. I agree to keep all information up to date, and to notify this doctor immediately of any changes in my health condition or health plan as they occur.

Patient Signature:_____ **Date:**_____

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Patient Name: _____

Gender (circle one): Male Female

Is this injury related to?

____ Auto Accident ____ Work Comp Injury _____Slip/Fall _____Other

If Yes, Please Explain:

History of Present Condition/Illness:

Previous Treatment and Conditions:

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Auto Accident Injury Information

What was your position in the vehicle?

( ) The driver ( ) The rear passenger
( ) The front passenger ( ) A pedestrian ( ) Other: _____

What type of vehicle were you driving?

( ) Compact car ( ) Full size car ( ) Full size truck ( ) Full size van
( ) Mid size car ( ) Compact truck ( ) Mini van ( ) Compact sport utility vehicle
( ) Full size sport utility vehicle ( ) Motorhome
( ) Motorcycle ( ) Bicycle ( ) Other: _____

What speed were you traveling at the time of the accident?

( ) Stopped at a stop light ( ) At a complete stop
( ) Slowing down at an intersection ( ) Moving slowly
( ) Traveling at approximately ___ mph ( ) Merging into traffic
( ) Traveling faster than 65 mph ( ) Other: _____

Who hit whom?

( ) Was struck by another vehicle ( ) Struck a stationary object
( ) Struck another vehicle ( ) other: _____

What was your vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear ( ) On the left rear
( ) On the right front ( ) On the middle front ( ) On the right rear ( ) The middle rear
( ) On the right side ( ) On the rear right side ( ) **On** the left side
( ) On the front right side ( ) On the middle right side ( ) **On** the front left side
( ) On the rear left side ( ) On the middle left side ( ) Other: _____

What speed was the other vehicle traveling?

( ) Stopped at a stop light ( ) At a complete stop
( ) Slowing down for an intersection ( ) Moving slowly
( ) Merging into traffic ( ) **Traveling** faster than 65 mph
( ) Traveling at approximately ___ mph ( ) Other: _____

What was the other vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear
( ) On the right front ( ) On the middle front ( ) On the right rear
( ) On the left rear ( ) On the right side ( ) On the rear right side
( ) On the middle rear ( ) On the front right side ( ) On the middle right side

( ) On the left side ( ) On the rear left side
( ) On the front left side ( ) On the middle left side ( ) Other: _____

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Were you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint
( ) Was wearing a shoulder restraint ( ) Was wearing a lap restraint
( ) Was not wearing any seat restraints ( ) Other: _____

What position were your vehicle head rests in?

( ) Did have a head rest which was adjusted in the lowest position
( ) Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position
( ) Was not equipped with a head rest
( ) Other: _____

Did your air bag deploy?

( ) Air bags were deployed ( ) Other:_____
( ) Air bags were not deployed

Were you prepared for the impact?

( ) Was completely surprised by the accident
( ) Saw the collision coming and braced appropriately
( ) Saw the collision coming ( ) Other: _____

What position was your body in just prior to impact?

( ) A straight position ( ) A position rotated to the left
( ) A tilted forward position ( ) A position rotated to the right
( ) A position that cannot be remembered
( ) Other: _____

What happened to your body the moment of impact?

( ) Body was tensed for impact ( ) Body violently torqued and twisted
( ) Body whipped violently forward and backward
( ) Body was thrown over the seat ( ) Body was thrown from the vehicle
( ) Body was thrown violently from side to side
( ) Body was pinned in the vehicle ( ) Body was badly cut and bruised
( ) Other: _____

What was your mental/emotional state immediately following the accident?

( ) Was not rendered unconscious by the impact of the accident
( ) Was not rendered unconscious but was shaken and disoriented
( ) Was not rendered unconscious but was shaken up
( ) Was not rendered unconscious but was disoriented
( ) Was rendered unconscious by the impact of the accident
( ) Other: _____

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention
( ) Did not receive medical attention ( ) Other: _____

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Where did you go immediately following the accident?

( ) Was taken to the hospital
( ) Was taken home
( ) Resumed activities
( ) Was taken to a personal physician
( ) Was taken to this office
( ) Other: _____

List each of your body parts that struck the following vehicle parts during the accident (Not all may apply).

Dashboard:
Which body part(s)?_____

Windshield:
Which body part(s)?_____

Steering Wheel:
Which body part(s)?_____

Right Door:
Which body part(s)?_____

Left Door:
Which body part(s)?_____

Seat Frame:
Which body part(s)?_____

Unknown Object:
Which body part(s)?_____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

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SOLUTIONS

Informed Consent

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

I hereby request and consent to treatment from this doctor/clinic including the performance of chiropractic adjustments and other chiropractic procedures, including physical therapy and rehab; diagnostic x-rays, medical examinations or other testing for my condition.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient's Signature_____ Date _____

Witness' Signature _____ Date_____

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