

HOW DID YOU FIND OUT ABOUT THE CLINIC?

Sign Google Facebook Radio Letter in Mail Attorney Other _____

If you have an attorney, please fill out their information below.

ATTORNEY INFORMATION

Law Office _____

Case Manager _____

Address _____

Phone _____

Fax _____

DOCUMENTS NEEDED

- COPY OF DRIVERS LICENSE
 - COPY OF POLICE REPORT
 - COPY OF ESTIMATE OF THE DAMAGE TO THE VEHICLE YOU WERE IN
-

Please provide your email address.



Confidential Patient Information

The following information is needed for our files so we can better serve you as a patient.

Patient # _____

Patient's full name _____

Address _____

Mailing Address _____

City, State & Zip _____

Birth date _____ Social Security # _____ - ____ - ____

Home phone (____) _____ Sex Male FemaleCell phone (____) _____ Texting YES NOMarital status single married widowed divorced other _____Date of last menstrual period _____ N/A

Nearest relative _____ Phone number _____

Reason for visit

Related to employment Yes No Date _____

Related to Automobile Yes No Date _____

Related to other Yes No Date _____

History Information

Have you had any past illness? Yes No _____

Family Physicians name and number _____

Any surgeries? Yes No _____

Any accidents? Yes No If yes, when? _____

Any MRI / CT / X-rays in the past year? Yes No _____

MEDICAL HISTORY

(IF ANY OF THE FOLLOWING ARE RELEVANT TO YOUR MEDICAL HISTORY, PLEASE CHECK THE ACCOMPANYING BOX)

 NO KNOWN MEDICAL HISTORY CANCER MUSCULAR DYSTROPHY RHEUMATIC FEVER POLIO MULTIPLE SCLEROSIS SCARLET FEVER TUBERCULOSIS CONVULSIONS NERVOUSNESS HIGH BLOOD PRESSURE EPILEPSY ASTHMA HEART TROUBLE CONCUSSION DIGESTIVE DISORDERS DIABETES DIZZINESS SINUS TROUBLE HEPATITIS HIV AIDS ARTHRITIS BACKACHES GERMAN MEASLES ANEMIA NEURITIS NUMBNESS VENEREAL DISEASE

PLEASE FILL OUT THE FOLLOWING INFORMATION:

OFFICE USE ONLY

Patient # _____

Name _____ Date _____

I have had **TRAUMA OR INJURY**: yes no describe the trauma: motor vehicle collision other: _____

Date of injury or onset of your symptoms: _____

What are **ALL** your **PRESENT COMPLAINTS**?

(IF ANY OF THE FOLLOWING ARE RELEVANT TO YOUR CURRENT SYMPTOMS, PLEASE **CHECK** THE ACCOMPANYING BOX)

- | | | |
|---|--|---|
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> LOWER BACK PAIN | <input type="checkbox"/> CHEST PAIN |
| <input type="checkbox"/> NECK SORENESS | <input type="checkbox"/> LOWER BACK SORENESS | <input type="checkbox"/> JAW PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> LOWER BACK STIFFNESS | <input type="checkbox"/> ELBOW PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> UPPER BACK PAIN | <input type="checkbox"/> HIP/PELVIC PAIN <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> WRIST PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> UPPER BACK SORENESS | <input type="checkbox"/> HIP/PELVIC SORENESS <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> HAND PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> UPPER BACK STIFFNESS | <input type="checkbox"/> HIP/PELVIC STIFFNESS <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> KNEE PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> MID BACK PAIN | <input type="checkbox"/> SHOULDER PAIN <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> ANKLE PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> MID BACK SORENESS | <input type="checkbox"/> SHOULDER SORENESS <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> MID BACK STIFFNESS | <input type="checkbox"/> SHOULDER STIFFNESS <input type="checkbox"/> L <input type="checkbox"/> R | |
| <input type="checkbox"/> TINGLING IN FINGERS <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> DOUBLE VISION |
| <input type="checkbox"/> TINGLING IN LEG <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> FAINTING | <input type="checkbox"/> LOSS OF SMELL |
| <input type="checkbox"/> NUMBNESS IN FINGERS <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> LOSS OF TASTE |
| <input type="checkbox"/> NUMBNESS IN LEG <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> EXTREME FATIGUE | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> EAR BUZZING / RINGING <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> NAUSEA / VOMITING |
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> LOSS OF MEMORY | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> LIGHTHEADEDNESS | <input type="checkbox"/> PAIN BEHIND THE EYES | <input type="checkbox"/> INCONTINENCE |
| <input type="checkbox"/> DIFFICULTY IN EXCESSIVE: <input type="checkbox"/> STANDING <input type="checkbox"/> WALKING <input type="checkbox"/> RIDING <input type="checkbox"/> BENDING | | |
| <input type="checkbox"/> PAIN RADIATING INTO: <input type="checkbox"/> NECK <input type="checkbox"/> BASE OF SKULL <input type="checkbox"/> ARM <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> SHOULDER <input type="checkbox"/> L <input type="checkbox"/> R | | |
| | <input type="checkbox"/> LEG <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> HIP/PELVIC <input type="checkbox"/> L <input type="checkbox"/> R | |

Have you seen any other doctors for these/this condition (if yes, list)? _____

Have you tried any of the following? ice heat stretching rest over the counter pain relievers N/A

Have you ever previously had similar symptoms (when and describe)? _____

Have you had prior chiropractic care (if yes, when)? _____

What is the severity of your pain **AND** other symptoms when they are at their **worst**?

- mild mild to moderate moderate moderate to severe severe very severe

Are your symptoms worse in morning afternoon evening night unaffected by time of day

Are your symptoms: constant (76% - 100%) frequent (51% - 75%) intermittent (26% - 50%) occasional (0% - 25%)

Are your symptoms: improving worsening not changing

Are your symptoms: dull sharp achy burning throbbing _____

Are your symptoms aggravated when you cough or sneeze? yes no

What makes your symptoms worse? _____

What makes your symptoms better? _____

List **ALL** medication that you take and reason _____

PATIENT INITIALS [_____]

OFFICE USE ONLY Patient # _____

Date _____ Name _____ Age _____
 Height _____ Weight _____ lbs. Right or Left handed

ACCIDENT HISTORY: (PLEASE CHECK, CIRCLE, OR FILL IN ANSWERS FOR ALL OF THE QUESTIONS)

Date of accident: _____ **Was the accident on the job?** Yes No
 Have you been able to work since the injury? Yes No Unemployed
 You were: Driver Front seat passenger Middle front seat passenger Rear seat: Left / Right
 How many people were in the vehicle you were in? _____ Vehicle was driven by: _____
 Year, make, model: _____

Your estimated speed at moment of accident: Stopped Slowing Accelerating - mph _____
 Describe the other vehicle (year, make, model): _____
 Time of day: Daylight Dawn Dusk Dark Road conditions: Dry Damp Wet Snow Ice

Was the accident in AR or TX other? _____ **In what county?** _____
Where did the accident occur? _____
Where was the impact? Rear (driver or passenger side) Front (driver or passenger side) Side impact (driver or passenger side)

Head restraints: The top of headrest was – Above Head Below Head Level with Head
 If adjustable, was the position of the head restraint altered by the accident? Yes No
 Was the seat back position altered by the accident? Yes No Was seat broken by the accident? Yes No
Seat belt: None Wearing Not wearing
 Did the **air bag** deploy? Yes No Were you struck by the air bag? Yes No
 Prior to the impact, your hands were: One on wheel Two on wheel N/A
 Were you aware of the impending crash, in time to react? (brace yourself) Yes No

DURING THE CRASH:

Your body position: Forward Turned Left Turned Right
 Your head position: Forward Turned Left Turned Right Up Down
 Did **you** strike any part of the vehicles interior? Yes No Unsure
 If yes, describe _____
 Wearing hat or glasses? Yes No If yes, were they still on after crash? Yes No
 Did you lose consciousness? Yes No If yes, how long _____
 Was your vehicle pushed by the impact? Yes No If yes, estimate how far? _____ ft
 Was your vehicle pushed into another vehicle? Yes No

AFTER THE ACCIDENT:

Estimated property damage of the vehicle you were in: None Minimal Moderate Major Totaled \$ _____
 Estimated damage to the other vehicle(s): None Minimal Moderate Major
 Were the police on the scene? Yes No If yes, was a report made? Yes No

When did the symptoms first appear? Immediately Hours (____) Days (____)
Describe Symptoms:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Back pain
<input type="checkbox"/> Left arm pain / numbness / tingling	<input type="checkbox"/> Left leg pain / numbness / tingling	<input type="checkbox"/> Left shoulder pain			
<input type="checkbox"/> Right arm pain / numbness / tingling	<input type="checkbox"/> Right leg pain / numbness / tingling	<input type="checkbox"/> Right shoulder pain			

Other Symptoms: _____

Where did you go after accident? Christus St. Michael Hospital – St. Michael Drive
 Christus Emergency Center – Gibson Lane Christus Health Pine Street (formally Wadley)
 Texarkana Emergency Center Signature Care Home _____

How did you get there? ambulance other _____

OFFICE USE ONLY

Patient # _____

Insurance (Responsible parties auto insurance)

Name of Insurance Company _____

Name of Insured _____ Policy # _____

Address of Insurance Company _____

City, State, Zip _____ Phone # _____

Claim # _____

Adjuster _____

Employer Information

Employer _____

Occupation _____

I give full permission to Back Pain Chiropractic Accident Injury Center & Interventional Pain Management to use any information to release to my family doctor and any other treating doctors regarding my conditions.

Patient name _____ Signature _____ Date _____

CONSENT TO TREAT A MINOR CHILD

I hereby authorize **Back Pain Chiropractic Clinic** to administer treatment as they deem necessary to my child.

Parent/Guardian _____ Signature _____ Date _____

Parent/Guardian Address _____

SS# _____ Phone # _____ DOB _____

INFORMED CONSENT FOR CARE & X-RAYS

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 seventy-two 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 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.

FEMALES: I ALSO HEREBY DECLARE THAT TO MY KNOWLEDGE; I AM NOT PREGNANT FOR X-RAY PURPOSES.

Patient Initials (____)

Print Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____