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.

_____

BACKPAIN Chiropractic

ACCIDENT INJURY CENTER & INTERVENTIONAL PAIN MANAGEMENT

OFFICE USE ONLY

Patient # _____

Confidential Patient Information

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

Patient's full name _____

Address _____

Mailing Address _____

City, State & Zip _____

Birth date _____ **Social Security #** _____-_____-_____

Home phone (_____) _____ Sex ☐ Male ☐ Female

Cell phone (_____) _____ Texting ☐ YES ☐ NO

Marital 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	☐ HIGH BLOOD PRESSURE	☐ HEPATITIS
☐ MUSCULAR DYSTROPHY	☐ EPILEPSY	☐ HIV ☐ AIDS
☐ RHEUMATIC FEVER	☐ ASTHMA	☐ ARTHRITIS
☐ POLIO	☐ HEART TROUBLE	☐ BACKACHES
☐ MULTIPLE SCLEROSIS	☐CONCUSSION	☐ GERMAN MEASLES
☐ SCARLET FEVER	☐ DIGESTIVE DISORDERS	☐ ANEMIA
☐ TUBERCULOSIS	☐ DIABETES	☐ NEURITIS
☐ CONVULSIONS	☐ DIZZINESS	☐ NUMBNESS
☐ NERVOUSNESS	☐ SINUS TROUBLE	☐ VENEREAL DISEASE

Back Pain Chiropractic
Accident Injury Center &
Interventional Pain Management
2006 N. State Line Ave. Texarkana, AR 71854

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)

☐ NECK **PAIN**	☐ LOWER BACK **PAIN**	☐ CHEST **PAIN**
☐ NECK **SORENESS**	☐ LOWER BACK **SORENESS**	☐ JAW **PAIN** ☐ **L** ☐ **R**
☐ NECK **STIFFNESS**	☐ LOWER BACK **STIFFNESS**	☐ ELBOW **PAIN** ☐ **L** ☐ **R**
☐ UPPER BACK **PAIN**	☐ HIP/PELVIC **PAIN** ☐ **L** ☐ **R**	☐ WRIST **PAIN** ☐ **L** ☐ **R**
☐ UPPER BACK **SORENESS**	☐ HIP/PELVIC **SORENESS** ☐ **L** ☐ **R**	☐ HAND **PAIN** ☐ **L** ☐ **R**
☐ UPPER BACK **STIFFNESS**	☐ HIP/PELVIC **STIFFNESS** ☐ **L** ☐ **R**	☐ KNEE **PAIN** ☐ **L** ☐ **R**
☐ MID BACK **PAIN**	☐ SHOULDER **PAIN** ☐ **L** ☐ **R**	☐ ANKLE **PAIN** ☐ **L** ☐ **R**
☐ MID BACK **SORENESS**	☐ SHOULDER **SORENESS** ☐ **L** ☐ **R**	☐ FOOT **PAIN** ☐ **L** ☐ **R**
☐ MID BACK **STIFFNESS**	☐ SHOULDER **STIFFNESS** ☐ **L** ☐ **R**	

☐ **TINGLING** IN FINGERS ☐ **L** ☐ **R**	☐ DIZZINESS	☐ DOUBLE VISION
☐ **TINGLING** IN LEG ☐ **L** ☐ **R**	☐ FAINTING	☐ LOSS OF SMELL
☐ **NUMBNESS** IN FINGERS ☐ **L** ☐ **R**	☐ INSOMNIA	☐ LOSS OF TASTE
☐ **NUMBNESS** IN LEG ☐ **L** ☐ **R**	☐ EXTREME FATIGUE	☐ SHORTNESS OF BREATH
☐ EAR BUZZING / RINGING ☐ **L** ☐ **R**	☐ IRRITABILITY	☐ NAUSEA / VOMITING
☐ HEADACHE	☐ ANXIETY	☐ CONSTIPATION
☐ LOSS OF MEMORY	☐ DEPRESSION	☐ DIARRHEA
☐ LIGHTHEADEDNESS	☐ PAIN BEHIND THE EYES	☐ INCONTINENCE

☐ DIFFICULTY IN EXCESSIVE: ☐ STANDING	☐ WALKING	☐ RIDING	☐ BENDING
☐ PAIN RADIATING INTO: ☐ NECK	☐ BASE OF SKULL	☐ ARM ☐ **L** ☐ **R**	☐ SHOULDER ☐ **L** ☐ **R**
	☐ LEG ☐ **L** ☐ **R**	☐ HIP/PELVIC	☐ **L** ☐ **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 [____]

Back Pain Chiropractic
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OFFICE USE ONLY
Patient # _____

Name _____ Age _____
Date_____ Your 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 this injury? ☐ Yes ☐ No ☐ Unemployed _____
You were: ☐ Driver ☐ Front seat passenger ☐ Middle front seat passenger ☐ Rear seat: Left / Right
Other _____ **How many people were in the vehicle you were in?** _____
Vehicle was driven by: _____
Describe the vehicle that you were in (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 other _____
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) If 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 **air bag** deploy? ☐ Yes ☐ No If yes, were you struck by the bag? ☐Yes ☐ No
Just 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
Your body position: ☐ Forward ☐ Turned Left ☐Turned Right Other _____
Your head position: ☐ Forward ☐ Turned Left ☐ Turned Right ☐ Up ☐ Down

DURING THE CRASH:
Did **you** strike any part of the vehicle's 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
After the accident, when did the symptoms first appear? ☐ Immediately ☐ Hours (___) ☐ Days (___)
Describe symptoms and when they appeared ☐ Headaches ☐ Dizziness ☐Nausea ☐ Disorientation ☐ Neck pain
☐ Back pain ☐ Shoulder pain ☐ Left Arm pain / numbness / tingling ☐ Right Arm pain / numbness / tingling
☐ Left Leg pain / numbness / tingling ☐ Right Leg pain / numbness / tingling ☐ other symptoms: _____

Where did you go after accident? ☐ St. Michael's ER ☐ Wadley ER ☐ other Hospital: _____ ☐ Home ☐Work
How did you get there? ☐ ambulance ☐ other _____

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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 _____

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Patient # _____

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 includerestoring 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 chiropracticadjustment 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 was1219 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: _____

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