Date: _____

Accurate Chiropractic Associates
800 Airport Rd, Suite 103, Milford DE 19963
302.422.0622 | Fax 302.424.8448

Last Name: _____ First Name: _____ M.I.: _____

Status: _____ Married _____ Single _____ Widowed _____ Divorced _____ Student

SSN#: _____ - ____ - _____ Date of Birth: _____/_____/_____ Sex: _____ M _____ F

Address: _____City_____State_____Zip_____

Phone Number: _____-_____-_____ Email: _____

Spouse/Parent/Guardian: _____ Phone Number: _____-_____-_____

Relationship: _____ Date of Birth: _____/_____/_____ Email: _____

Insurance Information

Insured Name: _____

Address: _____City_____State_____Zip_____

Policy or I.D. Number: _____ Claim Number: _____

Insurance Company: _____

Address: _____City_____State_____Zip_____

Patient's relationship to insured: ____ Self ____ Spouse ____ Child ____Other: _____

Is this a work related injury? ___ Yes ___No Date of Accident: _____/_____/_____

Is this an auto accident? ___ Yes ___ No Time of Accident: _____ ___ AM ___PM

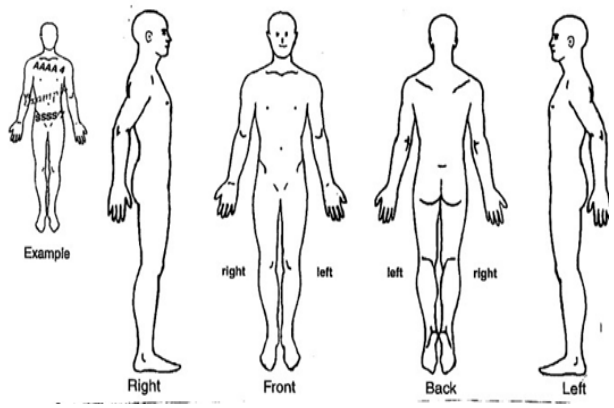
Is there a law suit pending? ___ Yes ___ No Was the accident reported? __ No __ Yes: _____

Name of Attorney: _____ City and State: _____

Company Name: _____ Phone Number: _____

Send the Bill to: _____ Insurance Name: _____

Address: _____City_____State_____Zip_____



Please **circle** the painful areas from the accident on the chart

_____
_____
_____
_____
_____
_____
_____
_____

Nature of Accident/Mechanism of injury:

Description of Incident

1. What happened? Describe in your words how the accident happened: _____
   _____
   _____
   _____
   _____
   _____

AUTO ACCIDENT ONLY

1. Were you: ___ Driver ___ Passenger ___ Front Seat ___ Back Seat ___ Seatbelt on ____ Off
2. Did you see the accident coming? ___ Yes ___ No
3. Did you brace for the impact? ___ Yes ___ No
4. Did you have your head turned at the time of impact? ___ Yes ___ No Which Direction? _____
5. Was your car braking? ___ Yes ___ No Stopped? ___ Yes ___ No
6. Was your car moving? ___ Yes ___ No
7. How fast would you estimate you were going? _____ M.P.H. The other vehicle? _____M.P.H
8. At the time of impact do you recall what parts of your body hit the inside of your car? _____
   _____
   _____
9. Were you able to get out of your car and walk around? ___ Yes ___ No, why? _____
   _____
10. Could you move all parts of your body? ___ Yes ___ No If not what couldn't you move? _____
    _____
11. Did you have bleeding cuts and bruises? ___ No ____ Yes, where? _____
    _____
12. Number of people in your vehicle? _____ Other: _____
13. What direction were you headed? ___ North ___ South ___ East ___ West
14. Direction were you headed? ___ North ___ South ___ East ___ West
15. Were you struck from: ___ Behind ___ Front ___ Left Side ___ Right Side
16. Were you knocked unconscious? ____ No ____ Yes, for how long? _____
17. Were police notified? ____ Yes ____ No

WORK ACCIDENT ONLY

1. Did you see the accident about to happen? ___ Yes ___No
2. Were you able to try and protect yourself from injury? ___ No ___ Yes, how? _____
3. Were you using safe work procedures? ___ Yes ____ No, how so? _____
4. Could you move all your body parts after the injury? ___ Yes ___ No, which ones? _____
5. Were you able to walk around after the injury? ___ Yes ____ No
6. Were you knocked unconscious? ___ No ___ Yes For how long? _____
7. Was the accident reported? ___ No ____ Yes, to who? _____

For this Accident

(Fill this out for auto accident and or work accident)

1. When did the pain begin? ___ All at once ___ Gradually became worse after the accident

   _____

   _____

   _____

   _____

2. Where do you have your pains now? _____

   _____

   _____

   _____

   _____

3. Is the condition staying the: ___ Same ___ Improving ___ Getting Worse
4. The pains are: ___ Constant ___ Comes and goes
5. The pain interferes with my: ___ Work ___ Sleep ___ Daily Routine ___ Recreation

   _____

   _____

6. Activities or movements that are painful to perform: ___ Sitting ___ Standing ___ Walking ___ Bending ___ Laying Down

   _____

   _____

7. What makes your condition/pain worse? _____
8. What makes your condition/pain better? _____
9. Did you have any pains before this accident? ___ No ___ Yes, what pains? _____

   _____

10. Have you noticed any restrictions because of this accident/injury? ___ No ___ Yes, explain? _____

    _____

11. Did you receive emergency care? ___ No ___ Yes, what hospital? _____
12. Were you taken by ambulance? ___ No ___ Yes ____ Other: _____
13. What treatment did you receive initially? _____

    _____

14. Have you had any X-Rays or MRI's or other tests done? ___ No ___ Yes, what testing and where: _____

    _____

15. Other doctors seen? Treatment? Response? Current? _____

    _____

    _____

    _____

    _____

<u>PREVIOUS ACCIDENTS, INJURIES, ILLNESSES</u>

1. Please list any and all accidents, injuries, and illnesses which may relate to this case:
   a. Accidents:_____

      _____

      _____

   b. Injuries:_____

      _____

      _____

   c. Illnesses:_____

      _____

2. Are there any complaints from a previous accident, injury, illness? If so, what? _____
_____
_____
3. Have you missed any time from work before this accident? ___ No ___ Yes, why? _____
    a. How long were you off? _____
4. Have you been rated as disabled/impaired? ___ No ___ Yes
    a. For a previous injury: _____ Rating: _____
5. Are you still receiving treatment from the previous injury? ___ Yes ___ No
    a. If so what? _____ Where? _____
6. What have been the results of that treatment? _____
_____

WORK STATUS

1. Have you lost time from work as a result of this accident/injury? ___ Yes ___ No
2. Last day worked:_____
3. Type of employment/job description: _____
4. Have you been rated as disabled/impaired as a result of this accident? ___No ___ Yes Rating: _____
5. Are you currently working? ___ No ___ Yes ___ Full ___ Light ___ Limited For how long? _____
6. If you have gone back to work, list the activities that are:
    a. Painful: _____
    b. Difficult: _____
    c. Other Problems:_____
7. Are there any reasons or problems you have with a fellow employee, supervisor, or management that need to be discussed? ___ No ___ Yes, explain? _____
_____
8. If you are not working, are you being compensated for the time lost from work? ___ No ___ Yes
    a. By Whom? _____
    _____

Review of Systems

1. Have you had previous chiropractic care? ___ No ___ Yes, Doctor? _____ Response: _____
2. Have you had any previous medical problems? ___ No ___ Yes, explain? _____
_____
3. Have you had any previous Musculo-skeletal injuries/problems/broken bones? ___ No ___ Yes, Explain? _____
_____
4. Have you had any previous male/female urinary problems? ___ No ___ Yes, explain? _____
_____
    a. Female: Number of children:_____
5. Have you had previous nervous system problems? (Before this accident) ____ No ____ Yes, explain? _____
_____
    a. Numbness: _____
    b. Tingling: _____
6. Do you have previous heart problems? ___ No ___ Yes, explain? _____
    a. Lung Problems? ____ No ___ Yes, explain? _____
    b. Blood Pressure problems? ____ No ___ Yes, explain? _____
7. Do you have previous ear problems/hearing loss? _____ No ____ Yes, which ear? __Lt __Rt What? _____
    a. Nose problems? ____ No ____ Yes, explain? _____
    b. Eye problems? ___ No ___ Yes, explain? _____

c. Throat problems? ___ No ___ Yes, explain? _____

8. Have you had any previous surgeries? _____
   _____
   _____
   _____
   _____
   _____
9. Do you wear Foot Orthotics? ____ Yes ____ No, have you ever gotten your feet scanned for orthotics? ____ Yes ___No, would you like a free foot scan and information on orthotics? ___ No ___ Yes

Additional information for the doctor:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient signature: _____ Date: _____

Date: _____

ACCURATE CHIROPRACTIC ASSOCIATES
800 AIRPORT RD, STE 103, MILFORD DE 19963
302.422.0622 | FAX 302.424.8448

Authorization to Release Health Information & Appointment Management Consent

Patient Name: _____ Date of Birth: _____
Phone Number: _____ Email: _____

In accordance with HIPAA regulations, this form allows you to designate individuals who may receive information about your medical care and/or assist in managing your appointments at Accurate Chiropractic.

I authorize Accurate Chiropractic to release information to and/or allow the following individual(s) to make changes to my appointments:

1. Name: _____
   DOB: _____
   Relationship: _____
   Phone: _____
2. Name: _____
   DOB: _____
   Relationship: _____
   Phone: _____

(You may write "N/A" if you do not wish to list additional names.)

This includes, but is not limited to:

- Scheduling, canceling, or rescheduling appointments
- Discussing treatment plans and progress
- Discussing billing and insurance matters
- Accessing relevant medical records or health information

I understand that:

- I may revoke this authorization at any time in writing.
- Revocation will not apply to information already released in reliance on this form.
- This authorization will remain in effect until revoked by me in writing.

Patient Signature: _____Date: _____