Patient Information Sheet / Accurate Chiropractic Associates, LLC

Milford Medical Center, 800 Airport Road, Suite 103, Milford, DE 19963 302-422-0622/fax 424-8448

Date: _____

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

Status: ___Married ___Single ___Widowed ___Divorced ___Children

SSN #: _____ Birth date: _____ Sex: ___M ___F

Address: _____

City: _____ Zip: _____

Telephone number: home_____ work_____

Permission to contact you at work or home about appointments/etc. ___Yes ___No

Patients Occupation: _____

Employer: _____

Employer Address: _____ Phone: _____

Name of spouse: _____ Phone: _____

Spouses Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referred by: _____ Your Email Address: _____

Insurance Information

Insured Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number 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 accident reported, to whom? _____

Name of Attorney: _____

Address: _____ If auto accident (agent) _____

City: _____ State: _____ Zip: _____ Company: _____

Phone: _____ Phone: _____

Send bill to: Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Use Only

Patient Number: _____ Type Pay: __CA __3P __BCBS __WC __AA __PI __MC Care started: _____

Diagnosis: ___Headache (784.0)
___Migraine (346.00)
___Cervical subluxations C1 to C7 (839.08 / 739.1)
___Thoracic subluxations T1 to T12 (839.21 / 739.2)
___Lumbar subluxations L1 to L5 (839.20 / 739.3)
___Sacroiliac subluxations S1 (839.42 / 739.4)
___Leg length inequality acquired (736.81)
___Sciatica (724.3)
___Sprain/stain (847.0) cervical
___Sprain/strain (847.1) thoracic
___Sprain/strain (847.2) lumbar
___Sprain/strain (847.3) sacroiliac
___Other_____
_____

Accurate Chiropractic Associates, LLC
800 Airport Road, Milford Medical Center, Suite 103
Milford, DE 19963
302-422-0622/FAX 302-422-0520

PERSONAL INJURY QUESTIONNAIRE

Name:_____ Date of birth:_____

Is this personal injury? __Yes. __No.
Is this auto accident? __Yes. __No.
Is this work related? __Yes. __No.

Today's date:_____

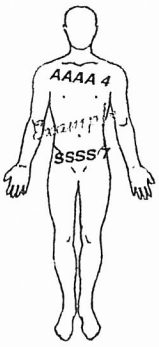
Date of injury:_____

Do you have an attorney? __Yes. __No. Name:_____
Address:_____

Please mark area(s) of injury or discomfort as shown in the example below. **Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).**

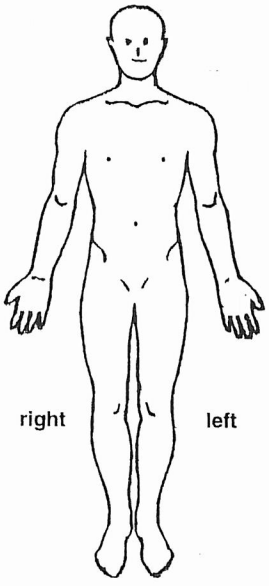
Description:	Numbness	Pins and Needels	Burning	Aching	Stabbing
Symbol:	NNN	PPP	BBB	AAA	SSS

☐ Circle any area of pain not represented by a symbol.

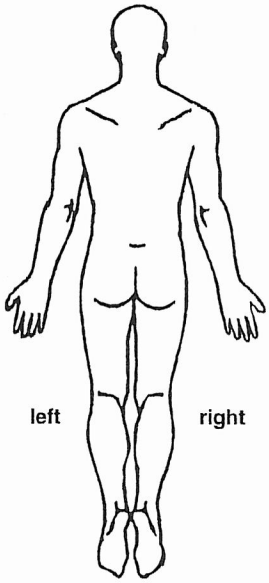


Example


Right



Front



Back


Left

Over

1. Nature of Accident/Mechanism of injury:

Description: (Fill this out for auto or work accident).

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

_____

_____

_____

_____

_____

_____

_____

A. Auto accident: (Fill this out if you were in an auto accident.)

1.Were you:__driver,__passenger,__front seat,__back seat,__seat belt on, __shoulder harness on.

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.

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. If not 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? __Yes. __No. Where?_____

_____

12. Number of people in your vehicle?_____Other:_____

13. What direction were you headed? __north,__south,__east,__west.

on (name of street/highway)_____

14. Direction of other vehicle? __north,__south,__east,__west.

on (name of street/highway)_____

15. Were you struck from: __behind, __front, __left side, __right side, other:_____

_____

16. Were you knocked unconscious? __Yes. __No. If yes, for how long?_____

17. Were police notified? __Yes. __No.

B. Work accident: (Fill this out if you were in a work related accident.)

1. Did you see the accident about to happen? __Yes. __No._____

2. Were you able to try and protect yourself from injury? __Yes. __No._____

3. Were you using safe work procedures? __Yes. __No._____

4. Could you move all of your body parts after the injury? __Yes. __No._____

5. Were you able to walk around after the injury? __Yes. __No._____

6. Were you knocked unconscious? __Yes. __No. For how long? _____

7. Was the accident reported? __Yes. __No. To whom?_____

Over

2. For this accident: (Fill this out for auto and or work accident))

A. Initial chief complaints. (Where did you first feel your pains? Location on your body.)

1. When did the pain begin? __All at once __Gradually became worse after the accident.

B. Where do you have your pains Now?

1. Is the condtion staying the: ___Same, ___Improving, ___Getting worse.
2. The pains are: ___Constant, ___Comes and goes.
3. The pain interferes with my: __work, __sleep, __daily routine, __recreation.
4. Activities or movements that are painful to perform:__sitting,__standing,__walking,__bending,__lying down
5. What makes your condition/pain worse?
6. What makes your condition/pain better?
7. Did you have any pains before this accident? __Yes. __No.
8. Have you noticed any restrictions as a result of this accident/injury? __Yes __No Describe:

C. Did you receive emergency care? __Yes. __No. Hospital:

1. Where you taken there by ambulance? __Yes. __No. other:
2. What treatment did you receive? Initial:
3. Have you had any x-rays or MRI's or other tests done?:
4. Other doctors seen? Treatment? Response? Current?

Over

3. Previous accidents, injuries, illnesses: (Fill this out for auto and/or work accident.)

1. Please list **any and all** accidents, injuries, and illnesses which may relate to this case.

Accidents:_____

_____

_____

Injuries:_____

_____

_____

Illnesses:_____

_____

_____

2. Are there any complications from a **previous** accident, injury, illness? If so what?:_____

_____

_____

3. Have you missed any time from work **before this accident**? __Yes. __No.
   a. How long were you off?_____. Why?_____
4. Have you been rated as disabled/impaired? __Yes.__No.
   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?_____

_____

4. 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? __Yes. __No. Rating:_____
5. Are you currently working? __Yes. __No. __Full, __Light, __Limited. For how long?_____
6. If you have gone back to work, list the activities that are:
   Painful:_____
   Difficult:_____
   Other problems:_____
7. Are there any reasons or problems you have with a fellow employee, supervisor, or management that need to be discussed? __Yes. __No. _____

_____

8. If you are not working, are you being compensated for the time lost from work? __Yes. __No.
   By whom?_____

_____

_____

_____

Over

5. Review of Systems

1. Have you had previous chiropractic care? __Yes. __No. Doctor:_____ Response:_____
2. Current chiropractic care? __Yes. __No. Doctor:_____ Response:_____
   How often do you go for treatment?_____
3. Have you had any previous medical problems? __Yes. __No. _____
4. Have you had any previous musculo-skeletal injuries/problems/broken bones? __Yes. __No. _____
5. Have you had any previous male/female urinary problems? __Yes. __No. _____
   Female: number of children_____
6. Have you had any previous stomach/bowel problems? __Yes. __No. _____
7. Have you had any previous nervous system problems? (Before this accident). __Yes. __No. _____
   a. Numbness:_____
   b. Tingling:_____
8. Do you have previous heart problems? __Yes. __No. What?_____
   Lung problems? __Yes. __No. What?_____
   Blood pressure problems? __Yes. __No. What?_____
9. Do you have previous ear problems/hearing loss __Yes. __No. Which ear? __lt __rt What?_____
   Nose problems? __Yes. __No. What?_____
   Eye problems? __Yes. __No. Which eye? __lt __rt What?_____
   Throat problems? __Yes. __No. What?_____
10. Have you had any previous surgeries? _____
11. Do you wear glasses? __Yes. __No. Contacts? __Yes. __No.
12. Do you have false teeth? __Yes. __No. Partial plate? __Yes. __No.
13. Do you have a hearing aid? __Yes. __No. Which ear? __L __R
14. Do you smoke? __Yes. __No. __Occasionally. Number per day? ____
15. Do you drink? __Yes. __No. __Occasionally. Number per day/week? ____
16. Do you take? __muscle relaxors, __pain killers, __insulin, __birth control pills, __over the counter drugs
    __other prescriptions_____
17. Do you wear? __heel lifts, __shoe lifts, __arch supports, __back brace, __artificial limbs.
18. Has any member of your family had the same or similiar condition or problem? __Yes. __No.
    What/Who?:_____

6. Since this accident I am:(What percentage are you better now.? From 0 (no better) to 100 % (all better).

I am _____% better.

20. Additional information:_____

_____Use back of this page if needed.

Accurate Chiropractic Associates, LLC, 800 Airport Road, Suite 103, Milford, DE 19963 302-422-0622

Pain Disability Questionnaire (PDQ) (American Medical Association, Guides to Impairment, 6th Edition)

Patient Name:_____ Date:_____ Patient #_____

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question and circle the one number on each scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally — Unable to work

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Cannot sit / stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Cannot walk/run

0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — On medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see people who are important to you as much as you would like?

No problem — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you feel more depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15, Are there emotional problems caused by your pain that interfere with your family, social, and or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10

Score_____ Examiner_____

Accurate Chiropractic Associates, LLC
Dr. Garrett Herring / Dr. Eric Ledford
800 Airport Road, Suite 103
Milford Medical Center
Milford, DE 19963
302-422-0622/ fax 302-424-8448

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I authorize the above-named doctor/doctors/clinic to administer chiropractic treatment to me and perform therapy, and I authorize such additional procedures, as the above-named doctor/doctors/clinic may consider desirable on the basis of findings and determinations made during the course of treatment. Also, I authorize the above-named doctor/doctors/clinic to consult with other professionals concerning my care and treatment.

I certify that I have read and understand the Authorization for Chiropractic Treatment and that I am aware of the possible risks and complications of chiropractic treatment. (See other side) **Initial:**_____

PAYMENT AGREEMENT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that this chiropractic office will accept payment from my insurance carrier, and prepare any necessary reports, and forms to assist me in collection from the insurance carrier, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for whatever charges are not paid by my insurance carrier. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand and agree that if my account is turned over to a collection agency that I will be responsible for all court fees and the percentage charged by the collection agency.

MEDICAL RECORDS

I understand and agree that this chiropractic office will maintain the privacy of my medical records. I understand and agree that from time to time it may be necessary for this chiropractic office to transmit copies of my records to my insurance carrier, other health care professionals, and the legal profession for routine use and disclosure. I authorize this office to transmit my records for such a review if necessary. The transmission of my records may be by oral communication, paper communication, and/or by electronic communication. I understand and agree that after a period of seven years inactivity at this office my medical records may be destroyed.

Please read and sign the other side of this form.

Accurate Chiropractic Associates, LLC

Informed Consent to Chiropractic Treatment (Possible Risks & Complications)

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry/wet hydrotherapy, massage or acupuncture may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment/manipulation. Complications although very rare could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment been described as very rare about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be ever further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered very rare.

Other treatment options which could be considered may include the following:

Over the counter analgesics: The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
Medical care: typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs can include numerous adverse undesirable side effects and patient dependence in a significant number of cases.
Hospitalization in conjunction with medical care adds a risk of exposure to virulent communicable disease in a significant number of cases.
Surgery in conjunction with medical care adds a risk of an adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

In spite of the additional risks noted with the other treatment options, medical care, analgesics, meditations, hospitalization and surgery may be necessary in certain cases. These options may be used in conjunction with your chiropractic care under the direction of your medical doctor.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the above unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment and the possibility and probability of risks. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Date:_____ **Patient Signature:**_____

Patient Printed Name:_____

Accurate Chiropractic Associates, LLC
Milford Medical Center
800 Airport Road, Suite 103
Milford, DE 19963
302-422-0622 / Fax 302-424-8448

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I _____, hereby authorize Accurate Chiropractic Assoc., LLC (the "Practice") to use and/or disclose to *other health care professionals/physicians, to appropriate third party payers, to practice staff for insurance/billing procedures, or anyone I so designate to receive* the following specific health information: *copies of my medical records, billing information.*

2. I understand that this authorization is valid until I revoke this authorization.

3. I understand that the purpose or use of this disclosure I am granting is to *provide information for treatment, payment and health care operations .*

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office may receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare may be affected if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it if so requested.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12. This authorization is valid as of ____/____/____, the date I have signed below.

_____ _____

Name of individual (Printed) Signature of individual

_____ _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if minor) Relationship

Witness:_____

Accurate Chiropractic Associates, LLC
Dr.Garrett Herring / Dr. Eric Ledford
Milford Medical Center
800 Airport Road, Suite 103
Milford, DE 19963-9803
302-422-0622 /fax 302-424-8448

Patient Request for Records

I, _____, do hereby authorize the release of my x-rays records, reports, medical records, reports or copies of such from_____ and request that they be transferred to:

Dr. _____
Address: 800 Airport Road, Suite 103
Milford Medical Center
Milford, DE 19963-9803
Fax 302-422-0520

Date: _____

Patient's Signature: _____

Date of records: _____

Date records sent: _____

Thank you for your time and attention regarding this matter.

ACCURATE CHIROPRACTIC ASSOCIATES
DR. HERRING/DR. LEDFORD
800 AIRPORT ROAD, SUITE 103
MILFORD, DE 19963
302-422-0622/302-424-8448 (FAX)

NAME: _____ DATE: _____

1. What is your current pain level (0 to 10)? _____

2. Have you had a flu shot within last 6 months?

   Yes_____ No_____

3. Have you had pneumonia shot within last 12 months?

   Yes_____ No_____

4. Please provide us with current weight and height.

   Weight_____

   Height_____

5. Do you use tobacco products?

   Yes_____ No_____

6. Please list all medications.

   _____

   _____