

Accident / Injury Questionnaire

Name: (Last, First MI) _____

Today's Date: _____

Date of Accident: ____/____/____ **Time:** ____:____ AM/PM

- Please describe the accident in as much detail as possible:

- Was anyone else in the vehicle with you? ☐ Yes ☐ No— (Number of people) _____
- Name of Driver, if not self: _____ • Name of Driver of other vehicle: _____
- Your Auto Ins: _____ Policy #: _____ Claim #: _____
Auto Ins. Address: _____ Phone #: _____
- Other's Auto Ins: _____ Policy #: _____ Claim #: _____
Auto Ins. Address: _____ Phone #: _____
- Your position in vehicle: _____
- Your Vehicle Type: Car / SUV / Truck • Other Vehicle Type: Car / SUV / Truck
- Were you wearing a seat belt? ☐ Yes ☐ No • Did the airbag deploy: ☐ Yes ☐ No
- Did your head hit the headrest? ☐ Yes ☐ No
- Where were you looking at time of impact?: _____
- Did you have any head injury from the accident? ☐ Yes ☐ No
- Did you contact the interior of the vehicle? ☐ Yes ☐ No
If yes, what body part and which part of the vehicle?: _____
- Did you lose consciousness? ☐ Yes ☐ No
- Where was impact on your car?: _____ • What was your estimated speed?: _____ MPH
- How much damage occurred to your car? Mild / Moderate / Severe
- Where was impact on their car?: _____ • What was their estimated speed?: _____ MPH
- How much damage occurred to their car? Mild / Moderate / Severe
- Was your vehicle towed from the scene? ☐ Yes ☐ No
- Were police at the scene? Yes / No
- Was a report filed? ☐ Yes ☐ No
- EMS on the scene? ☐ Yes ☐ No
- Were you transported by ambulance? ☐ Yes ☐ No
- Have you received any care since the accident? ☐ Yes ☐ No
If yes, by whom?: _____
- Did you have complaints in the involved area before the accident? ☐ Yes ☐ No
If yes, were they present at the time of the accident? ☐ Yes ☐ No
- Did you feel the pain immediately after the accident? ☐ Yes ☐ No ☐ Later that day ☐ Next day ☐ When?: _____
- Are you symptoms: ☐ Improving? ☐ Getting Worse? ☐ The Same?
- Are your work activities restricted as a result of this accident?: ☐ Yes ☐ No
Have you missed any work as a result? ☐ Yes ☐ No

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/____

PATIENT INFORMATION

Name: (First MI Last) _____ Preferred Name: _____

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

Mobile: _____ Home: _____ Work: _____

Email: _____

PLEASE READ

Mobile Text Messaging (SMS) and Email Consent

Date of Birth: _____ Gender: ☐ Male ☐ Female

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Employed: ☐ No ☐ Yes (Occupation) _____

Employer: _____

Initials

*I HEREBY CONSENT and state my preference to have my doctor and other staff at Whole Body Chiropractic to communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, appointments, reminders, and billing.

Initials

I DO NOT consent to SMS or email communication.

* I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

*Referred By: (Name) _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

Race & Ethnicity: (Choose up to 2)

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____

Home: _____ Mobile: _____

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

Primary Care Physician: _____

Doctor's Phone: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: _____

Will we be working with insurance? ☐ No ☐ Yes (Details)

Primary: _____ ID#: _____

Secondary: _____ ID#: _____

Where would you like statements sent?

☐ Self ☐ Other (Details below)

Name: _____

Address: _____

Phone: _____ Email: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: _____

Secondary Complaints: _____

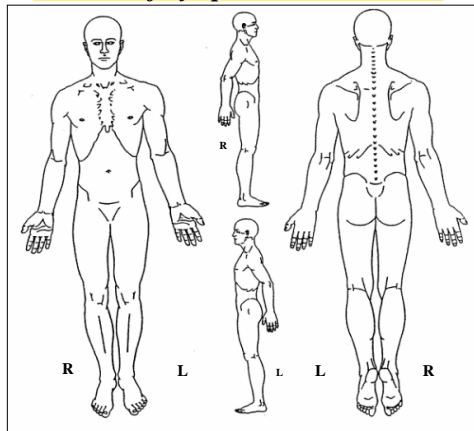
When did it start? ____/____/____ **What happened?** _____

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Please mark

Location of Symptoms and Radiation



P __ Pain T __ Tender
N __ Numb H __ Hypoesthesia
S __ Spasm

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

- ☐ No ☐ Yes (Please indicate on drawing)

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women: Are you pregnant?**

- ☐ No Last Menstrual Period: ____/____/____
- ☐ Yes Due date: ____/____/____

Present Illness Comments:

Prescription Medications & Supplements: ☐ None

☐ Yes (List - Name, dosage, frequency) _____

Allergies to Medications: ☐ No known drug allergies

☐ Yes (List - Name and reaction) _____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you **ever** had any of the following? (Please select all that apply and use comments to elaborate.)

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (Type) _____
- ☐ Blood Clots
- ☐ Cancer (Type) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Hospitalizations: (Non-surgical with Date)

Surgeries: (If yes, provide type & surgery date)

- ☐ Cancer _____
- ☐ Orthopedic
 - Shoulder – R / L _____
 - Elbow/Forearm – R / L _____
 - Wrist/Hand – R / L _____
 - Hip – R / L _____
 - Knee – R / L _____
 - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
 - Neck: _____
 - Back: _____
- ☐ Other: _____

Medical History Comments:

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- ☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

SOCIAL AND OCCUPATIONAL HISTORY

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: _____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: If current smoker, amount = _____

- ☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

- ☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

- ☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

- ☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: _____

Today's Date: _____ Patient Name: _____ Account No: _____

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SEAMLESS™ EHR

Revision Date 03/14/2017

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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent **PLEASE READ AND CHOOSE ONE OPTION**

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

☐ I, _____ (print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Patient Signature: X Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

I instruct checks to be made payable to Whole Body Chiropractic, and payment to be sent to 2233 W. 15th Street, Plano, TX 75075.

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient Signature: X Date: _____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

**PLEASE
READ**

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient Signature: X Date: _____

WHOLE BODY CHIROPRACTIC

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE OF ACTION: CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Brent Money, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Whole Body Chiropractic, 2233 W. 15th Street, Plano, TX 75075.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Whole Body Chiropractic and to send any and all checks to 2233 W. 15th Street, Plano, TX 75075.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

Signature_____Date:_____

Signature_____Date:_____

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____

PRINTED

Signature

Date

Total Score _____