Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information:

Today's Date ____________________
Name ____________________ Home Phone ____________________
I prefer to be called ____________________ Work Phone ____________________
Address ____________________ Email ____________________
____________________ Social Security # ____________________
____________________ Date of Birth ____________________
Sex **Male** **Female** Height ____' ____" Weight ______ lbs
Occupation ____________________ Marital Status ____________________
Employer ____________________ No of Children ____________________
Address ____________________
If minor, name of parent or guardian ____________________
Who should we contact in case of an emergency? ____________________
Relation ____________________ Phone ____________________
Address ____________________
Attorney ____________________ Phone ____________________
Primary Care Physician ____________________ Phone ____________________
How did you hear about our office? ____________________
Have you ever been to a chiropractor before? **YES** **NO** If so, whom? ____________________

Health Insurance Information:

Insurance Company ____________________ Policy number ____________________
Policy Holder's Name ____________________ Social Security # ____________________
Address ____________________ Phone ____________________

Auto Insurance Information:

Insurance Company ____________________ Policy number ____________________
Address ____________________ Phone ____________________
Adjustor Name ____________________ Claim # ____________________

Accident Information:

Date ____________ Time ________ AM PM Was it reported to the police? **YES** **NO**
Was a traffic violation issued? **YES** **NO** To whom? ____________________

Location of accident (Street, Town) ____________________ # of other passengers ______
Were there other witnesses? **YES** **NO** Make/model of vehicle you were in __________

Please explain in detail how the accident occurred ____________________
____
Please list symptoms felt immediately after the accident ____________________
____
In which direction were you headed? **N** **S** **E** **W** Approx. speed of vehicle ___ MPH

FOX

SPINE + SPORTS

M E D I C I N E

Did the impact to your vehicle come from the: **FRONT REAR RIGHT LEFT OTHER**

During impact, were you facing: **RIGHT LEFT FORWARD**

Were you **AWARE** or **SURPRISED** by the impact?

Were you the **DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER**?

Were you wearing a seat belt? **SHOULDER HARNESS LAP HARNESS**

Was the vehicle equipped with air bags? **YES NO** Did they inflate? **YES NO**

In relation to the base of your skull, where was the headrest? **ABOVE BELOW AT BASE**

What did your vehicle impact? **ANOTHER VEHICLE OTHER** ____________________

If another vehicle, what was the make/model? ____________ Direction ______Speed ______MPH

Did any part of your body strike anything in the vehicle? **YES NO** Describe ____________

Did the accident render you unconscious? **YES NO** If yes, for how long? ____________

Post-Injury Information:

Have you seen any other doctor(s) since the accident? **YES NO** Name ____________

When did you go? **IMMEDIATELY NEXT DAY 2 DAYS PLUS**

How did you get there? **AMBULANCE PRIVATE TRANSPORTATION**

Name of hospital and/or attending doctor: ____________________

Was he/she a: **D.C. M.D. D.O. D.D.S.**

Please describe any treatment you received ____________________

Were X-Rays done? **YES NO** An MRI? **YES NO** CAT scan? **YES NO**

Was medication prescribed? **YES NO** If yes, what? ____________________

Have you missed any work since the accident? **YES NO** Date(s) ____________

Are your work activities restricted as a result of your injury? **YES NO**

Indicate the symptoms that are a result of this accident:

DIZZINESS	**DIFFICULTY SLEEPING**	**JAW PROBLEMS**	**NAUSEA**
MEMORY LOSS	**ARM/SHOULDER PAIN**	**IRRITABILITY**	**BACK PAIN**
HEADACHE(S)	**NUMB HANDS/FINGERS**	**FATIGUE**	**LOW BACK PAIN**
BLURRED VISION	**TENSION**	**CHEST PAIN**	**BACK STIFFNESS**
BUZZING IN EAR	**NECK PAIN**	**SHORT BREATH**	**LEG PAIN**
EARS RINGING	**NECK STIFF**	**STOMACH UPSET**	**NUMB FEET/TOES**

OTHER ____________________

Did you ever experience similar symptoms prior to the accident? **YES NO**

Has your condition **IMPROVED WORSENED** or **STAYED SAME** since the accident?

Is your condition affecting your **WORK SLEEP** or **DAILY ROUTINE**? Please explain ______

____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

___ Lying on Back	___ Lying on Side	___ Lying on stomach	___ Sitting
___ Standing	___ Stretching	___ Lovemaking	___ Walking
___ Running	___ Sports	___ Working	___ Lifting
___ Bending	___ Kneeling	___ Pulling	___ Reaching

How many hours are in your normal workday? ____________

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

STANDING	**OPERATING EQUIPMENT**	**DRIVING**	**SITTING**
TWISTING	**WORK W/ARMS ABOVE HEAD**	**WALKING**	**CRAWLING**
TYPING	**LIFTING**	**BENDING**	**STOOPING**

What positions can you work in with minimum physical effort, and for how long? ___________________

Do you work with others who can help you with any heavy lifting? **YES** **NO**

While in recovery, are there any light duty tasks you could request? **YES** **NO**

Health History

Have you ever had any of the following diseases or conditions?

HEART ATTACK or STROKE	**HEART SURGERY or PACEMAKER**	**HEART MURMUR**
CONGENITAL HEART DEFECT	**MITRAL VALVE COLLAPSE**	**ARTIFICIAL VALVES**
ALCOHOL/DRUG ABUSE	**VENEREAL DISEASE**	**HEPATITIS**
HIV+/AIDS	**SHINGLES**	**CANCER**
FREQUENT NECK PAIN	**EMPHYSEMA**	**ANEMIA**
HIGH/LOW BLOOD PRESSURE	**PSYCHIATRIC PROBLEMS**	**RHEUMATIC FEVER**
SEVERE/FREQ. HEADACHES	**KIDNEY PROBLEMS**	**ULCERS/COLONITIS**
FAINTING/SEIZURE/EPILEPSY	**SINUS PROBLEMS**	**ASTHMA**
DIABETES	**DIFFICULTY BREATHING**	**TUBERCULOSIS**
LOWER BACK PROBLEMS	**ARTIFICIAL BONES/JOINTS**	**ARTHRITIS**

Please list **any other** medical conditions that you have or have ever had. ____________________

____

Please list any allergies. ____

____

Please list previous surgeries and dates. _________________________________

____

Please list any past motor vehicle accidents or traumas and dates. ____________________

____

Is there anything else about your health history or family health history that you feel is important to share? ____

____

Do you exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: ______/_____/______

Do you smoke? **YES** **NO** How much? _____________ How long? _____________

Are you wearing: **ORTHOTICS** **HEEL LIFTS** **ARCH SUPPORTS**

For women: Are you taking birth control? **YES** **NO**

Are you pregnant? **YES** **NO** How long? ________ Nursing? **YES** **NO**

Patient/Legal Guardian Signature________________________________ **Date** ______________

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name: ____

I hereby authorize payment to be made directly to FOX Spine & Sports Medicine , of all benefits which may be due and payable under insurance coverage for the above named Patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to FOX Spine & Sports Medicine .

Furthermore, I hereby IRREVOCABLY ASSIGN to FOX Spine & Sports Medicine , the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida statutes for any service and or charges provided by FOX Spine & Sports Medicine .

Signature of Patient or responsible party: ______________________________________

Signature of witness: ____

OFFICE POLICIES

The following are FOX Spine & Sports Medicine's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.

Consent for Treatment. The Patient and/or the undersigned, give PBFCSM and Dr. Christopher J. Fox and/or Dr. Jacques D. Etheart my/our permission to evaluate and treat the Patient's injury or condition. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care treatment.

Appointment Scheduling and Cancellation Policy. At FOX Spine & Sports Medicine, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

Office Visits. We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings!

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Patient/Parent or Legal Guardian Signature______________________________**Date** ____________

DISPUTE RESOLUTION

Arbitration. The undersigned and the Patient agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by FOX Spine & Sports Medicine and/or Dr. Christopher Fox or Dr. Jacques D. Etheart (jointly, "PBFCSM"), shall be resolved exclusively by binding arbitration pursuant to the Florida Arbitration Code, Florida Statutes 682. This includes any injury or losses by you or your children on the premises. Arbitration shall occur in West Palm Beach, Florida and nowhere else.

County Court Exception. The undersigned, the Patient, and PBFCSM all agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by PBFCSM which is within the monetary jurisdiction of county court, Florida Statute 34.01(1)(c), may be brought in arbitration as set forth above or Palm Beach County Court and nowhere else.

Severability/Jury Waiver. In the event any portion of this Chiropractic Care Agreement is deemed unenforceable, that portion shall be severed and all other provisions remain in full force and effect. The undersigned, the Patient, and PBFCSM agree that each has waived its rights to a jury trial for any disputes or claims among them.

Chiropractic Care. The undersigned and the Patient agree and acknowledge that PBFCSM provides chiropractic care only. The Patient is advised and agrees to consult a medical doctor routinely and as needed. Please ask questions about your health!

Patient/Parent or Legal Guardian Signature________________________________**Date** _____________

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ______________________________ have read a copy of **FOX Spine and Sports Medicine &**
Patient Name
Sports Medicine's notice of Patient Privacy Practices.

_____________________________________ ______________________
Signature of Patient or Parent or Legal Guardian Date

CHIROPRACTIC INFORMED CONSENT

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from FOX Spine & Sports Medicine and Dr. Christopher J. Fox and Dr. Jacques D. Etheart (jointly, "FSSM").

Dr. Fox is a "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods. *See* Florida Statute 460.403(3)(b).

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. *See* Fla.Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. *See* Fla.Stat. 460.403(9)(a).

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by PBFCSM. I hereby give my informed consent to receive chiropractic medicine from PBFCSM.

____
Patient Name/Signature (and date)

____
Guardian/Parent's Name/Signature (and date)