NUZZI CHIROPRACTIC
LIFESTYLE WELLNESS CENTER

AUTO ACCIDENT INITIAL HISTORY FORM

Name: _____ ***Date:***_____

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

Home Phone: _____/_____/_____ ***Work:*** _____/_____/_____ ***Ext:*** _____ ***Cell:*** _____/_____/_____

E-Mail address (for emergencies and newsletters only)

_____

Date of Birth: _____/_____/_____***Age:***_____***Height:***__***ft.***___***in.*** ***Weight:***_____

Marital Status: ***M S W D*** ***Name of Spouse:***_____

Children? Y N ***Names/Ages of Children:***_____

Employer:_____***Occupation:***_____

Emergency Contact Person: _____***Relation:*** _____ ***Address:***_____

_____***City:***_____***State:***_____***Zip:***_____ ***Phone:*** _____/_____/_____ ***Who referred you here?*** _____

ACCIDENT HISTORY

Date of Accident ____/_____/_____ ***Time of Accident*** _____ ☐ ***AM*** ☐ ***PM Where?*** _____

Details of the Accident

_____

_____

Make/Model/Year of your Vehicle_____ ***Make/Model/Year other vehicle***_____

Driver or Passenger? _____ ☐***Lap belt*** ☐***Shoulder Belt*** ☐***Both*** ☐***No Seat Belt Worn*** ***Passengers? Y N Number***___

How far is the top of the headrest from the top of your head? Approximately _____***inches*** ☐***Above*** ☐***Below*** ☐ ***Not Sure***

How far away is the headrest from the back of your head? Approximately _____***inches away*** ☐ ***Not Sure***

Were police at the accident scene? ☐***Yes*** ☐***No Is there an accident report?*** ☐***Yes*** ☐***No*** ***Road:*** ☐***Wet*** ☐***Dry*** ☐***Icy***

Did you go to the hospital? ☐ ***Yes*** ☐ ***No*** ***By ambulance?*** ☐ ***Yes*** ☐ ***No***

List exams and tests you received at the hospital

_____

_____

Diagnosis, home treatment, medication by hospital?

_____

Were you ☐***Aware of the approaching collision prior to impact, or did it*** ☐***Catch you totally by surprise?***

Any cuts or bruises from this accident?

_____

Did you lose consciousness (black out) upon impact? ☐***Yes*** ☐***No*** ***How long were you out?***

_____

Did you experience a flash of light/explosion in your head, or "see stars"? ☐***Yes*** ☐***No***

Was your vehicle stopped at the time of impact? ☐***Yes*** ☐***No*** ***Was your vehicle*** ☐***slowing down*** ☐***gaining speed*** ☐***traveling at a steady rate*** ***Was your foot on the brake?*** ☐***Yes*** ☐***No***

☐***Automatic transmission*** ☐***Standard transmission*** ***Was the car in gear?*** ☐***Yes*** ☐***No***

Was the other vehicle stopped at the time of the accident? ☐***Yes*** ☐***No***

Was this vehicle ☐***slowing down*** ☐***gaining speed*** ☐***traveling at a steady rate?***

Was the trunk of your body pointed straight forward at the time of collision? ☐***Yes*** ☐***No***

If no, what direction was it turned?

_____

Was your head pointed straight forward at the time of collision? ☐Yes ☐No
If no, what direction was it turned?

_____

Did any body parts strike something in the car?

_____

What parts of the vehicle broke? ☐Windshield ☐Front Seat Back ☐Steering Wheel ☐Other_____
What is the estimated cost of damage to your vehicle?

_____

Please list the symptoms caused by this accident.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Overall, at this time, is your condition: ☐ Becoming worse ☐ Remaining the same ☐Improving
Please list other doctors or health care practitioners you have seen for this accident.

1. _____
2. _____
3. _____

Are you currently taking any prescription drugs or over the counter drugs? ☐ Yes ☐ No (List Below)

_____

_____

Are you currently taking any vitamins or supplements? ☐ Yes ☐ No (List Below)

_____

Have you stopped or changed your exercise program due to your accident? ☐ Yes ☐No
If so, what modifications have been made?

_____

What else are your problems preventing you from doing? Sports _____ Hobbies _____
Family/Kids _____ Work _____ Other _____

Before this accident, were you suffering from any of the symptoms above? ☐ Yes ☐ No (If yes, please explain)

_____

Prior to this accident, have you been involved in any similar types of injuries? ☐ Yes ☐ No (List Below)

If yes, when	***Did you recover?***	***Any residual symptoms?***

_____

WORK HISTORY

At the time of this injury did you have a job? ☐ Yes ☐ No
Employer/Address _____ Occupation _____
Did you miss any work because of your injuries? ☐ Yes ☐ No From: ____/____/____ To: ____/____/____
Returned to work on: _____/_____/_____ Light or Full Duty?

_____

Did you lose your job because of your injuries? ☐Yes ☐ No Did you change jobs because of your injuries? ☐ Yes ☐ No
Explain your job requirements, including positions and postures:

_____

Have you seen any other chiropractors? Y N Name:

_____

Location: _____ Reason/diagnosis:

_____

*Any surgeries in your past? (Include dates)*_____

_____

Who is your primary physician? Name: _____ *Location:* _____
When is the last time you visited your physician? Date: _____ *Reason:*

_____

Have you ever smoked? Y N Do you smoke now? Y N
If yes, how long, how much, and when did you quit?

_____

Please list previous accidents/injuries, including major childhood traumas with dates and hospitalizations.

_____

_____

What childhood illnesses have you had (measles, chicken pox, etc.)? ____ *Usual Other*

_____

FAMILY HISTORY

Do any of your blood family have, or had, any of the following?

PROBLEM	*YES*	*NO*	*PROBLEM*	*YES*	*NO*
Chronic Back/Neck Pain	☐	☐	*Stroke*	☐	☐
Surgery	☐	☐	*Heart Problems*	☐	☐
Scoliosis	☐	☐	*High Blood Pressure*	☐	☐
Diabetes	☐	☐	*Arthritis*	☐	☐

Other

_____

Have you ever suffered a stroke, heart attack, or vascular disease? ☐ *Yes* ☐ *No*
Has anyone in your family suffered a stroke, heart attack, or vascular disease? ☐ *Yes* ☐ *No (List Below)*

_____

_____

Females: Do you take birth control pills? ☐*Yes* ☐*No When did you start?* _____
Have you ever taken birth control pills in the past? ☐ *Yes* ☐ *No If yes, for how long (dates)?*

_____

Check any of the following conditions you have had or do have:

__ *Allergies*
__ *Sinus Problems*
__ *Asthma*
__ *Anemia*
__ *Arthritis*
__ *Cancer*
__ *Depression*
__ *Diabetes*
__ *Digestive Problems*
__ *Drug Abuse/Addiction*
__ *Alcoholism*
__ *Stress*
__ *High Blood Pressure*
__ *Eczema*
__ *Other Skin Problems*
__ *Headaches*
__ *Migraines*
__ *Heart Disease*
__ *Heart Attack*
__ *Menstrual Problems*
__ *Multiple Sclerosis*
__ *Stroke*
__ *Weight Problems*
__ *Ringing in Ears*
__ *Dizzy/Balance Problems*
__ *Neck Pain*
__ *Mid Back Pain*
__ *Low Back Pain*
__ *Shoulder Pain L R*
__ *Elbow Pain L R*
__ *Hand Pain L R*
__ *Hip Pain L R*
__ *Leg Pain L R*
__ *Knee Pain L R*
__ *Foot Pain L R*
__ *Carpal Tunnel L R*
__ *(Other)*_____

☐ *Yes* ☐*No Any personality/emotional changes? If so, what?* _____
☐ *Yes* ☐*No Have you lost any sense of smell, or are you more sensitive to odors?*
☐ *Yes* ☐*No Do you see spots or any disturbances or changes to your vision?*
☐*Yes* ☐*No Do your eyes and/or mouth get dry?*
☐ *Yes* ☐*No Does your heart feel like it races?*
☐ *Yes* ☐*No Do you break a sweat easy?*
☐ *Yes* ☐*No Do you sweat more on one side of the body than the other?*
☐ *Yes* ☐*No Have you noticed any changes in your bowel or bladder function? If so, what?* _____

_____

☐ *Yes* ☐*No Any changes in sexual function? If so, what?* _____
☐ *Yes* ☐*No Have you noticed any short or long-term memory changes?*

☐ *Yes* ☐*No* *Are you fatigued?*
☐ *Yes* ☐*No* *Do you have any muscle twitches?*
☐ *Yes* ☐*No* *Do you consume caffeine (coffee, soda, tea)? If so, how much?* _____
☐ *Yes* ☐*No* *Do you choke on foods or liquids?*

How old are your parents and what is their state of health?

_____
If deceased, cause of death:

_____
Siblings, ages, and health:

_____

CONSENT TO TREATMENT AUTHORIZATION

By my signature below, I certify that the above information is correct. I authorize Nuzzi Chiropractic Lifestyle Wellness Center, to perform an examination, order x-rays if necessary, and administer chiropractic treatment. I authorize Nuzzi Chiropractic Lifestyle Wellness Center to contact other health care providers I have to coordinate my care, and to release information to my other providers for coordination of care, and to release my health information for insurance reimbursement purposes.

_____ _____/_____/_____
Patient Signature *Date*

INSURANCE ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct _____ Insurance Company to make payment directly to: **Nuzzi Chiropractic Lifestyle Wellness Center***, the professional or chiropractic benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.* ***THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY****. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.* ***A photocopy of this Assignment shall be considered as effective and valid as the original*** *dated this _____ day of _____ 20_____.*

_____
Patient Signature
By my signature below, I understand that if my health insurance denies the charges, I am responsible for payment of my bill.

_____
Patient Signature

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have been offered a copy of Nuzzi Chiropractic Lifestyle Wellness Center Notice of Privacy Practices for Protected Health Information, and I have been told that a copy is available at the front desk at any time.

_____ _____/_____/_____
Patient Signature *Date*

*PATIENT PREGNANCY DISCLAIMER (*FEMALES ONLY)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time,

_____ *I am sure that I am not pregnant* _____ *It is possible that I could be pregnant* _____ *I am pregnant*

_____ _____/_____/_____
Patient Signature *Date*

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent. Chiropractic adjustments are moving of bones with the doctor's hands or with the use of a machine, table, or instrument. Frequently adjustments created a "pop" or "click" sound/sensation in the area being treated. In this office we may use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. However, one study (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimates that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke. Newer research (Spine, Feb. 15, 2008) found because the association between chiropractic visits and VBA stroke is not greater than the association between PCP visits and VBA stroke, there is no excess risk of VBA stroke from chiropractic care.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. This result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we may use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise cure for any symptoms, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

The practice of chiropractic in this office consists of:

1. ***Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments and resultant nerve interference).***
2. ***Adjustment of the spine for the purpose of correcting vertebral subluxations.***
3. ***Education and encouragement of our patients/practice members to become aware of and responsible to their well-being.***
4. ***Empowerment of our patient/practice members as to the inherent healing capabilities of the human body.***

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

I understand the practice of chiropractic as outlined, I am aware of the risks as outlined above, and wish to receive care at NUZZI CHIROPRACTIC LIFESTYLE WELLNESS CENTER for myself/my family.

_____ _____/_____/_____
Patient Signature ***Date***

_____ _____/_____/_____
Authorized Provider Representative Printed ***Date***

Witnessing signing of: ☐ Authorization to treat ☐ Insurance assignment ☐ Privacy Notice ☐ Pregnancy Disclaimer
☐ Informed Consent