Confidential Patient / Injury Information

Patient Name _____ DOB _____/_____/_____ Age: _____ M☐/F☐

Address _____ Apt# _____SS# _____

City _____ State _____ Zip Code _____

Phone _____ Alt. Phone _____ Email _____

Employer _____ Occupation _____

Address: _____City _____

State _____ Zip Code _____Work Phone _____ Ext _____

Single☐ Married ☐Divorced☐ Widowed ☐Emergency Contact_____

Phone _____ Spouse _____ Referred by _____

CLAIM INFORMATION:

Cause: Auto Accident ☐Personal Injury ☐Work Injury ☐Other _____

Type of Claim: Cash ☐ Group Health ☐ Personal Injury ☐Worker's Comp ☐ Other _____

INSURANCE INFORMATION:

Relationship to the Insured: Self ☐Spouse ☐Child ☐Other☐

Insured's Employer (Same as Above☐) Other_____ Insured's SS#: (as Above☐)

Other SS#_____ Insured's DOB: (as Above☐) _____/_____/_____

Primary Insurance Co. _____Address _____

City _____State _____ Zip Code _____ Phone _____Ext _____

Policy #_____Group# _____

Secondary Insurance Co. _____Address _____

City _____State _____ Zip Code _____ Phone _____Ext _____

Policy #_____Group# _____

Attorney _____Address _____

City _____State _____ Zip Code _____ Phone _____Ext _____

AUTHORIZATIONS:

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. Additionally, I hereby authorize release of any medical information to any third party as I deem necessary for my medical benefit.

B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe to this office by my attorney, out of the proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and/or services rendered.

C. I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.

D. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature _____ Date_____

Guardian's Signature _____ Date_____

Confidential Patient / Injury Information

Date: _____ DOI: _____

Name: _____ Age: _____ DOB: _____ Height: _____ Weight: _____

Handedness: R / L /A: Race_____ Occupation: _____FT / PT Part

Type of Injury: Auto ☐ Work ☐ Personal ☐ Sports ☐ Other _____Time _____AM/PM

Were others involved? Yes ☐ No ☐ if yes Names: _____

Please describe the incident in your own words: _____

_____

_____

_____

IF INJURY INVOVLED A VEHICLE (IF NOT SKIP TO HEAD POSTION)

Were you the driver? ☐ Passenger ☐ front seat ☐ back seat ☐ other ☐

Year and Model of your vehicle_____ People in your vehicle _____

What direction were you traveling? N ☐ S ☐ E ☐ W ☐ Street _____

Where you stopped? Yes ☐ No ☐ If no, your Est. speed____ Struck from the F ☐ R ☐ P ☐ D ☐

Year and Model of other vehicle(s)_____

What direction of other vehicle? N ☐ S ☐ E ☐ W ☐ Street _____

Where they stopped? Yes ☐ No ☐ If no, their Est. speed_____ Struck from the F ☐ R ☐ P ☐ D ☐

_____

Road Conditions? Wet ☐ Dry ☐ Visibility? Good ☐ Poor ☐ Wearing a seat belt? Yes ☐ No ☐

With shoulder harness? Yes ☐ No ☐ Were you aware of the impending collision? Yes ☐ No ☐

If yes, did you brace and how? _____ Did the air bags deploy? Yes ☐ No ☐

Were the police notified? Yes ☐ No ☐ If yes, was a report filed? Yes ☐ No ☐

HEAD POSTION

Your head position at injury? _____ Did you lose consciousness? Yes ☐ No ☐ If yes, please explain: _____

_____

Were you taken anywhere by ambulance or private party? Yes ☐ No ☐ If yes, please explain any testing, medications and/or treatment you received: _____

_____

_____

How did you feel immediately following the incident? _____

_____

How did you feel later that day? _____

_____

How did you feel the next day? _____

_____

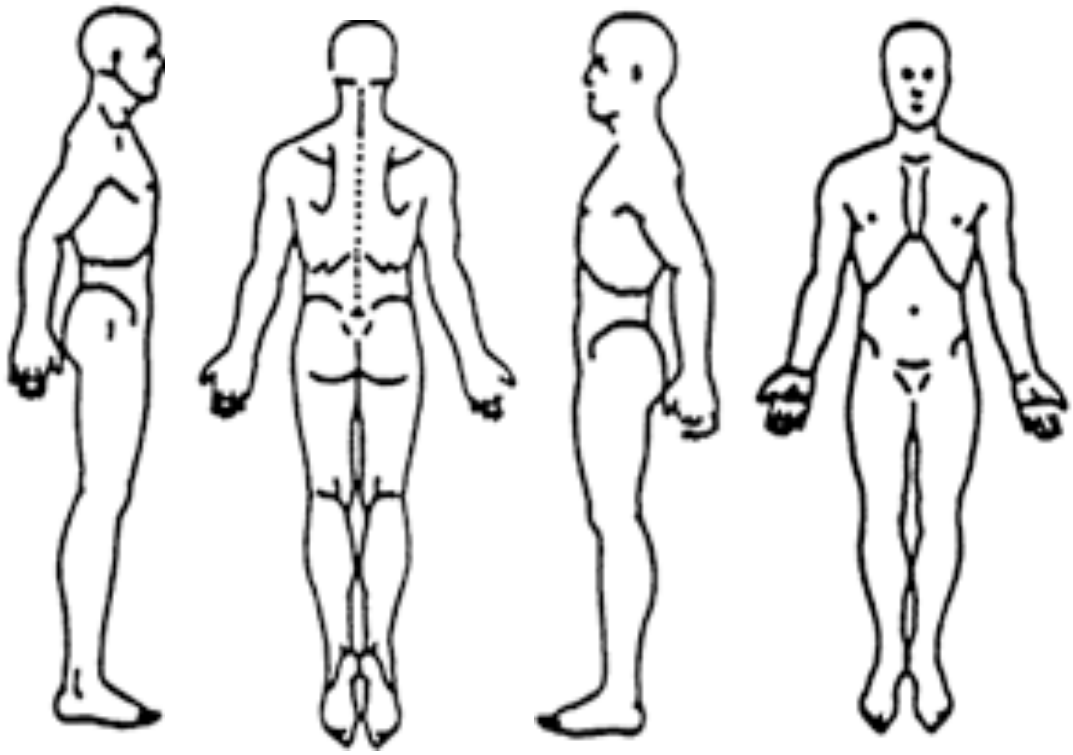
How did you feel the following days? _____

_____

Confidential Patient / Injury Information

Name: _____ Date of Birth: _____

Please mark all areas of pain on the diagram:



Please list your current health concerns related to your injuries in order of priority:

_____

_____

Did your injuries occur while performing your job duties? Yes ☐ No ☐ If yes, please explain:

_____

Has your condition impaired performing your job duties? Yes ☐ No ☐ If yes, please explain:

_____

Have you lost time from work as a result of your injuries? Yes ☐ No ☐ If yes, please explain:

_____

How do these condition(s) impair your daily activities? _____

_____

How do these condition(s) impair your social activities? _____

_____

What makes your condition it better? _____

_____

What makes your condition it worse? _____

_____

Anything else you would like to share? _____

_____

Confidential Patient / Injury Information

Name: _____ Date of Birth: _____

Did you have any health complaints prior to your injuries? Yes ____ No ____ If yes, please explain:

_____

_____

Have you ever had your current injuries before in this incident? Yes ____ No ____ If yes, when and where?

_____

_____

If you have experience any of the following conditions in the past please mark (P) on the line provided.
If you are currently experiencing any of the following conditions please mark (C) on the line provided.

____Heart Attack
____Stroke
____High BP
____Diabetes
____Cancer
____Arthritis
____Kidney Stones
____Gall Bladder
____Prostate Problems
____Nausea/Vomiting
____Dizziness
____Headache
____Memory Loss
____Fainting
____Hearing Loss
____Ringing in Ears
____Asthma
____Diarrhea
____Constipation
____Trouble Swallowing
____Indigestion/Reflux
____ Abdominal Pain
____Difficulty w/ Urination
____Blood in Urine
____Blood in Stool
____Gout
____Muscle pain
____Joint Replacement
____Joint pain
____Unexplained Fatigue
____Unexplained Weight Loss
____Unexplained Weight Gain
____Recent Fever / Sweats
____Chest Pains Discomfort
____ Palpitations
____ Shortness of Breath
____ Anxiety/Stress
____ Sleep Problems
____ Coughing /Wheezing
____Change in Vision
____Glaucoma
____Cold/Heat Intolerance
____Increased Thirst

AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date_____

Guardian's Signature _____ Date_____

Confidential Patient / Injury Information

Name: _____ Date of Birth: _____

Place a check on the line in the first (1st) column if you had any of these symptoms before the collision.
Place a check on the line in the second (2nd) column if you had any of these symptoms after the collision.
Place a check on the line in the third (3rd) column if you are experiencing any of these symptoms today.
Leave the last column blank (for office use only).

Thinking / Remembering	Before DOI	After DOI	Today	Today 0/10
Difficulty thinking clearly	☐	☐	☐	_____
Thinking slowed down and/or mentally fatigued	☐	☐	☐	_____
Difficulty concentrating and/or staying focused	☐	☐	☐	_____
Difficulty staying organized	☐	☐	☐	_____
Difficulty learning and/or remembering new information	☐	☐	☐	_____
Short term memory loss	☐	☐	☐	_____
Long term memory loss	☐	☐	☐	_____
Difficulty finding words and/or expressing yourself	☐	☐	☐	_____
Difficulty with reading and/or comprehension	☐	☐	☐	_____
Difficulty with numbers and/or forgetting numbers	☐	☐	☐	_____
Difficulty recognizing people	☐	☐	☐	_____
Difficulty recognizing where you are	☐	☐	☐	_____
Missing periods of time	☐	☐	☐	_____
Loss of insight and/or poor judgment	☐	☐	☐	_____

_____
_____
_____
_____
_____
_____

Sleep	Before DOI	After DOI	Today	Today 0/10
Sleeping more than usual	☐	☐	☐	_____
Sleeping less than usual	☐	☐	☐	_____
Having trouble falling asleep	☐	☐	☐	_____
Having trouble staying asleep (added to list)	☐	☐	☐	_____

_____
_____
_____
_____
_____

Confidential Patient / Injury Information

Name: _____ Date of Birth: _____

Leave the last column blank (for office use only).

Physical	Before DOI	After DOI	Today	Today 0/10
Physically fatigued and/or fatiguing more easily	☐	☐	☐	_____
Headache	☐	☐	☐	_____
Fuzzy, blurry and/or double vision	☐	☐	☐	_____
Nausea and/or vomiting	☐	☐	☐	_____
Dizziness and/or light headed	☐	☐	☐	_____
Balance problems / feelings of falling and/or spinning	☐	☐	☐	_____
Difficulty speaking and/or writing	☐	☐	☐	_____
Decrease or loss of smell	☐	☐	☐	_____
Decrease or loss of taste	☐	☐	☐	_____
Sensitivity to noise, and/or easily upset / irritated by loud noise	☐	☐	☐	_____
Sensitivity to light, and/or easily upset / irritated by bright light	☐	☐	☐	_____
Intolerance to heat and/or cold	☐	☐	☐	_____

_____

_____

_____

_____

_____

Emotion / Mood / Affect	Before DOI	After DOI	Today	Today 0/10
Feeling more emotional and/or emotionally fragile	☐	☐	☐	_____
Feeling nervous / restlessness and/or anxious	☐	☐	☐	_____
Feeling irritable / frustrated / and/or uncooperative	☐	☐	☐	_____
Feeling impatient / angry / and/or aggressive	☐	☐	☐	_____
Feeling less / lacking emotion	☐	☐	☐	_____
Feeling apathetic / without motivation	☐	☐	☐	_____
Feeling depressed, sad and/or tearful	☐	☐	☐	_____
Personality changes	☐	☐	☐	_____
Withdrawal from family / friends	☐	☐	☐	_____
Relationship difficulties	☐	☐	☐	_____
Neglecting personal hygiene	☐	☐	☐	_____
Resistant to health care	☐	☐	☐	_____
Socially Inappropriate behavior	☐	☐	☐	_____
Unusual sexual behavior and/or loss of libido	☐	☐	☐	_____

_____

_____

_____

Confidential Patient / Injury Information

Name: _____ Date of Birth: _____

Leave the last column blank (for office use only).

Head, Face and Neck Pain	Before DOI	After DOI	Today	Today 0/10
Headache - right/left	☐	☐	☐	_____
Face - right/left	☐	☐	☐	_____
Upper Neck - right/left/midline	☐	☐	☐	_____
Lower Neck - right/left/midline	☐	☐	☐	_____

Back Pain	Before DOI	After DOI	Today	Today 0/10
Upper Back - right/left/midline	☐	☐	☐	_____
Middle Back - right/left/midline	☐	☐	☐	_____
Lower Back - right/left/midline	☐	☐	☐	_____
Pelvis - right/left/midline	☐	☐	☐	_____

Upper Body Pain	Before DOI	After DOI	Today	Today 0/10
Shoulders - right/left/front/back	☐	☐	☐	_____
Arms - right/left	☐	☐	☐	_____
Hands - right/left	☐	☐	☐	_____
Fingers - right/left	☐	☐	☐	_____

Lower Body Pain	Before DOI	After DOI	Today	Today 0/10
Hips - right/left	☐	☐	☐	_____
Thighs - right/left	☐	☐	☐	_____
Legs - right/left	☐	☐	☐	_____
Feet - right/left	☐	☐	☐	_____

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.

Patient's Signature _____ Date_____

Guardian's Signature _____ Date_____

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____
(Also list maiden name/other names used)
I hereby request and authorize:

Live Well Health, PC • PO Box 2415 • Wilsonville, OR 97070
503 855-4465 Phone 971-249-8767 Fax

☐ To Disclose information to: ☐ To Receive Information from:

Name/Provider: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Name/Provider: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Name/Provider: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Name/Provider: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Information to be disclosed includes copies of:

☐ Entire Record	☐ Reports	☐ Physical Exam Forms
☐ X-Ray Reports	☐ CT Scan Reports	☐ Other, specify
☐ Daily Chart Notes	☐ MRI / Reports	_____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is a valid as the original.

_____ Date: _____
Signature of Patient
OR
_____ Date: _____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.
Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient of legal representative.