Back To Life Chiropractic
4045 East Bell Rd, Suite 107
Phoenix, AZ. 85032
Office: (480) 703-1834

VEHICLE ACCIDENT INFORMATION

Patient Name: _____Date:_____
Address: _____ City:_____ State:_____ Zip:_____
Phone:_____ Sex: Male / Female Date of Birth: _____
Email:_____ Circle: Married Divorced Widowed Separated Single Minor
Patient's Employer/School: _____ Occupation: _____
Emergency Contact: _____ Phone: _____
Date of Accident_____ Time of Accident _____ AM / PM
Please describe the accident in your own words:
_____
_____

Were you the:
☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian
How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____
City/State _____
Nearest Intersection with road/street _____
Driving Conditions ☐Dry ☐Wet ☐Ice ☐Other _____
Which directions were you headed? _____
Speed you were traveling? _____

VEHICLE

Make and Model of vehicle you were in:
_____
Were you wearing a seatbelt? ☐YES ☐NO
If yes, what type? ☐Lap ☐Shoulder
Was the Vehicle equipped with airbags? ☐YES ☐NO
If yes, did it/they inflate properly? ☐YES ☐NO
Did your seat have a headrest? ☐YES ☐NO
If yes, what was the position of the headrest?
☐LOW ☐MID POSITION ☐HIGH
Damage to your vehicle: Mild Moderate Totaled

OTHER VEHICLE

Make and Model of the other vehicle
_____
Which direction was the other vehicle headed?
_____
Speed other vehicle was traveling?
_____
Damage to other vehicle: Mild Moderate Totaled

IMPACT

Did your car impact another vehicle? ☐YES ☐NO
Did your car impact a structure? ☐YES ☐NO
If yes, explain _____
_____
Did any part of your body strike anything in the Vehicle?
☐YES ☐NO If yes, Explain_____
_____
Was impact from?
☐Front ☐Rear ☐Left ☐Right ☐Other _____
At the time were you:
☐ Looking straight ahead ☐ Looking to the Right
☐ Looking to the Left ☐ Looking Down
☐ Looking Up
Were both hands on the steering wheel? ☐Yes ☐No
If no, which hand was on the wheel? ☐Right ☐Left
Was your foot on the brake? ☐Yes ☐No
If yes, which foot was on the brake? ☐Right ☐Left
Were you:
☐Surprised by Impact ☐Braced for Impact

POLICE

Did the police come to the accident site? ☐YES ☐NO
Were there any witnesses? ☐YES ☐NO
Was a police report filed? ☐YES ☐NO
Was a traffic violation issued? ☐YES ☐NO
If yes, to whom? _____
_____

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Name:_____ Today's Date: _____

Date of Accident:_____ ☐ Driver ☐ Passenger

Please provide as much information as possible so your case can be setup to your financial advantage. In the start of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage overpayment may occur. We only need to be paid once, so all overpayments will be reimbursed to you at the time you are released from care. _____ (Patient Initials)

Primary Health Insurance (Health Insurance that covers you)

Insured Name:_____ **Insured Date of Birth:**_____

Insurance Name:_____

ID #:_____ **Group #:**_____

Insurance Phone #:_____

Medical Payment Coverage: On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med-Pay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming your finger in the car door. Using this portion of the policy cannot raise your premium or affect your record in any way. In fact, this is exactly why you pay "Med Pay" on your insurance policy.

Claimant:_____**Policy Holder's Name:**_____

Insurance Name:_____ **Ph #:**_____

Policy #:_____ **Claim #:**_____

Adjuster's Name:_____ **Ph #:**_____

****The above information is printed on the proof of insurance card that is kept in the automobile****

Third Party Liability: This is the insurance information for the person who was in the "other car". The information can be found on the accident report.

Driver's Name:_____**Policy Holder's Name:** _____

Insurance Name:_____ **Insurance Ph #:**_____

Policy #: _____**Claim #:**_____

Adjuster's Name:_____ **Ph #:**_____

Attorney Information:

Name: _____**Firm:** _____

Contact Person: _____**Address:**_____

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NOTICE OF DOCTORS LIEN

_____ _____
Attorney or Adjuster / Licenciado **DOI** / Dia de Accidente

_____ _____
Address / Direccion **Patient** / Paciente

_____ _____
City, State, Zip / Ciudad, Estado, Zona Postal **Date of Birth** / Fecha de Nacimiento

I do hereby authorize **Back To Life Chiropractic, Inc.** to furnish you, my attorney/adjuster, with a full report of the examination, diagnosis, treatment, prognosis, and any other pertinent information regarding my care as a result of the accident in which I was involved.

I hereby authorize and direct you, my attorney/adjuster, to pay directly to said doctor's office such sums as may be due and owing them for medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, medical insurance payment, judgement, or verdict, as may be necessary to adequately protect said doctor's office. I hereby further give a lien on my case to said doctor's office against any and all proceeds of my settlement, medical insurance payment, judgement, or verdict which may be paid to you, my attorney/adjuster, or to myself as the result of the injuries for which I have been treated or injuries connected therewith.

I understand that I am directly and fully responsible to said doctor's office for all medical bills submitted by him for service rendered to me , and that his agreement is made solely for said doctor's additional protection, and in consideration of his awaiting payment. I further understand that such payment is not contingent upon any settlement, medical insurance payment, judgment, or verdict by which I may eventually recover said fee. It is also my understanding that if payment is not made and account is referred to collections, patient will pay all reasonable attorney fees, court costs and collection agency fees.

Yo autorizo a **Back To Life Chiropractic, Inc.** para proporcionar a ustedes, mi Licenciado/Ajustador, con un reporte completo de mi examinacion, diagnostico, tratamiento, pronostico, y otra informacion. Referente al accidente en cual yo estuve envuelto, yo autorizo directamente a mi Licenciado/Ajustador para pagar cualquier suma que la oficina de Back To Life Chiropractic no proporcione por servicio medico por este accidente y retener alguna suma semejante de cualquier arreglo para pagos medicos es algo necesario para protecion de la oficina del doctor. Tambien yo autorizo si se puede adelantar a la oficina del doctor cualquier pago medico de aseguranza o de cualquier arreglo con mi caso ya sea por medio de algun veredicto o juicio como resultado de mis lesiones por las cuales yo fui atendido y tratado.

Yo entiendo perfectamente que soy el responsable por cualquier cuenta medica hecha por la oficina del doctor y este acuerdo es unicamente proteccion adicional para la oficina del doctor en consideracion por espera de su pago. Yo adelanto y entiendo que dicho pago es no contingente, en cualquier arreglo, pago medico o aseguaranza juicio veredicto de dicho recobro eventual que yo tenga.

Date/Fecha**:** _____ **Patient's Signature:** _____
Firma del Paciente

Date:_____ **Witness Signature:**_____

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PATIENT CONDITION

Reason for this visit _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51 -75 % of the time) ☐ Intermittently (1-25 % of the time)

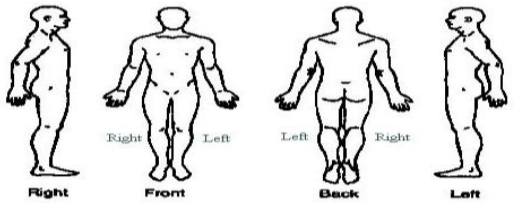
How would you describe the type of pain?

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
☐ Diffuse ☐ Shooting w/motion ☐ Stabbing w/ motion ☐ Electric like w/ motion ☐ Other:_____

How are your symptoms changing with time?

☐ Getting worse ☐ Staying the Same ☐ Getting Better

Indicate on the drawings below where you have pain/symptoms:



Were you unconscious immediately after the accident? ☐ YES ☐ NO

Please describe how you felt immediately after the accident: _____
_____

Did you go to the hospital? ☐ YES ☐ NO

When did you go? ☐ Immediately after the accident ☐ Next Day ☐ Two or More Days After Accident

How did you get to the hospital? ☐ Ambulance ☐ Drove Self ☐ Police ☐ Someone else

Name of Hospital _____ Name of Doctor _____

Diagnosis _____

Treatment Received _____

X-Rays Taken _____

If you have had any of the following symptoms since your injury, please **X**:

☐ Arm/Shoulder Pain ☐ Feet/Toe Numbness ☐ Neck Pain ☐ Back Pain ☐ Hand/Finger Pain ☐ Neck Stiffness ☐ Headaches
☐ Sleep Difficulty ☐ Ear Buzzing ☐ Irritability ☐ Dizziness ☐ Jaw Problems ☐ Upset Stomach ☐ Chest Pain
☐ Blurred Vision ☐ Memory Loss ☐ Leg Pain ☐ Tension ☐ Fatigue ☐ Nausea ☐ Hip Pain
☐ Loss of Taste ☐ Anxious ☐ Cold Feet ☐ Cold Hands ☐ Nervousness ☐ Pain behind eyes

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist
☐ Massage Therapist ☐ Physical Therapist ☐ Other:_____ ☐ No one

I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other that vertebral subluxations. However, if during the course of chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate/and adjust a minor child.

I, _____being the parent or legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission to receive chiropractic care.

_____ _____
(Signature) (Date)