



Madison Heights Chiropractic Center

AUTOMOBILE ACCIDENT INTAKE & HISTORY FORM (NEW PATIENT ONLY)

Patient Name _____ Male _____ Female _____ Other _____
(last) (first) (middle initial)

Address _____ City _____ State _____ Zip _____

Email _____

(Email is required for Patient Portal Access)

Cell Phone _____ Home Phone _____ Are you Pregnant? YES NO Unsure

Date of Birth _____ Age _____
(month) (day) (year)

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Number of Children _____

Name of Spouse _____ Name of Children _____

Patient's Occupation or Profession _____

Employed by _____ Business Phone _____

Is the above patient under the age of 18? ___ No ___ Yes If Yes, Parent/Guardian please complete line below:

Name _____ Relationship _____ SSN# _____

Address _____ Phone _____

Primary Care Physician (PCP) Name _____ Phone Number _____

Date of your last visit with your PCP & Yearly Physical: _____

Past Surgeries _____

How did you hear about our office? **Referred by** _____

Have you had an X-Ray/MRI/CT (circle) done **AFTER** the accident? YES / NO Where? Neck Mid-Back Low Back

Have you had chiropractic before? _____ Where? _____

Have you had Pain Management: _____ Current _____ Previous _____ Never

Do you have additional health insurance? No Yes If yes: _____ Policy# _____

Do you have any of the following(circle): HSA FSA None

Auto Insurance Company Name: _____

Agent/Adjuster's Name: _____ Claim# _____

Date your Auto Accident Occurred: _____ **City/State:** _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING BEFORE THE ACCIDENT? IF YES, MARK “X

(This applies to symptoms that you have experienced in the past, from birth to BEFORE the accident)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Acid Reflux/Heartburn | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> <i>Marfans</i> | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> <i>Ehlers-Danlos (Type IV)</i> | <input type="checkbox"/> Menstrual Cramps and Pain | <input type="checkbox"/> Shooting Head Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Shoulder Tightness |
| <input type="checkbox"/> Base of Neck Pain | <input type="checkbox"/> <i>Fibromuscular Dystrophy</i> | <input type="checkbox"/> Mid Back Pain when Sleeping | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> <i>Balance/Coordination Problems</i> | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Migraines | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Bladder Troubles | <input type="checkbox"/> Head Feels Heavy | <input type="checkbox"/> Muscle Spasms in Mid/Low Back | <input type="checkbox"/> Stiff Mid Back |
| <input type="checkbox"/> <i>Bleeding Disorders</i> | <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle Spasms in Neck | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> <i>Blood in Urine or Stool</i> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nausea or Upset Stomach | <input type="checkbox"/> Stomach Disorder |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> <i>Strokes</i> |
| <input type="checkbox"/> <i>Bruising Easily</i> | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> <i>Numbness/Weakness of head or face</i> | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Numbness of Arm or Hand | <input type="checkbox"/> Throbbing Head Pain |
| <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Numbness of Legs or Feet | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> <i>Hypertension/HBP</i> | <input type="checkbox"/> <i>Nystagmus/Rapid Eye Mov't</i> | <input type="checkbox"/> Tingling in Fingers |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <i>Lightheadedness</i> | <input type="checkbox"/> Pain in Shoulder Blades | <input type="checkbox"/> Trouble Bending |
| <input type="checkbox"/> <i>Chronic Lung Disease</i> | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pain into feet | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Clicking or Grinding in Neck | <input type="checkbox"/> Inner Tension | <input type="checkbox"/> Pain into Legs | <input type="checkbox"/> <i>Trouble Speaking (Speech)</i> |
| <input type="checkbox"/> Cluster Headaches | <input type="checkbox"/> Intestinal Gas | <input type="checkbox"/> Pain into the Buttock | <input type="checkbox"/> <i>Trouble Swallowing</i> |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Irritability | <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Trouble Twisting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cool Hands | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Pins and Needles in Arms/Hands | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Knots in the Back Muscle | <input type="checkbox"/> Pins and Needles in Back/Legs/Feet | <input type="checkbox"/> <i>Upper Respiratory Infection</i> |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> <i>Polycystic Kidney Disease</i> | <input type="checkbox"/> <i>Urinary Tract Infections</i> |
| <input type="checkbox"/> <i>Dizziness</i> | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Postmenopausal | <input type="checkbox"/> <i>Vision problems</i> |
| <input type="checkbox"/> Drop Attack | <input type="checkbox"/> Lower Mid Back Pain | <input type="checkbox"/> Ringing in Ears | |
| | | <input type="checkbox"/> Sciatic Pain | |

Personal history of:(circle all that apply)

Anemia, Arthritis, Arteriosclerosis (hardening/thickening of artery walls), Asthma, Cancer: _____, Cardiovascular Problems (Circulation issues, Swelling, etc), Congestive Heart Failure, COPD, COVID, Crohn's, Depression, Diabetes, Dizziness/Fainting, Headaches, Heart Disease, Heart Attack, Heart Problems, Hepatitis, HIV, High Blood Pressure, Hypertension, Irritable Bowel Syndrome, Kidney Problems, Liver Disease, Low Blood Pressure, Osteoporosis, Pacemaker, Respiratory Problems, Rheumatoid Arthritis, Seizures, Stroke, Systemic Disease, Tuberculosis, Thyroid Problems, Other: _____

***Have you received the COVID19 Vaccine? ___ No ___ Yes. Have you had the COVID virus? ___ No ___ Yes (This question MUST be answered for our records)**

Family History:

Has your mother had any of the above YES / NO, IF Yes, list conditions? _____

Is your mother deceased? YES / NO

Has your father had any of the above YES / NO, IF Yes, list conditions? _____

Is your father deceased? YES / NO

Has your grandparents, sister, brother had any of the above? YES / NO, IF Yes, list conditions? _____

Social History:

Do you drink alcohol? Yes / No If Yes, How Many? 1-2 3-4 5+ How Often? Daily Weekly Monthly Occasional/Social

Do you (circle one) smoke/vape tobacco? Never Former smoker Occasional/social (Light) Current (Daily) Smokeless tobacco

Do you (circle one) smoke / vape: Marijuana THC CBD Other: _____

Do you use (circle): THC / CBD products

Have you used illegal drugs? Yes / No

Do you exercise? YES / No, If Yes Circle one: Daily Weekly Monthly

If Yes, What Kind? Yoga/Pilates Weight Training Running/Jogging Other: _____

Accident Questionnaire:

Part 1:

		Yes	No	Unsure
1.	Did you strike your head in the accident?			
2.	Do you have a clear recollection of the accident and/or events before and following the accident: Did you see the car come to a stop and people walking up to the car? <i>(If the answer is No, please answer 2a.)</i>			
2.a	Did you have a loss of consciousness (you blacked out for a few seconds or longer), If Yes, please answer 2b.			
2.b	How long did you lose consciousness for? _____			
3.	Have you experienced headaches since the accident?			
4.	Have you experienced dizziness since the accident?			
5.	Have you experienced Nausea and/or vomiting at the scene of the accident?			
6.	Have you experienced blurred vision?			
7.	Have you experienced Ringing in the ears?			
8.	Have you experienced excessive fatigue; physical and/or mental?			
9.	Have you experienced confusion or disorientation (forgetfulness)?			
10.	Have you experienced memory problems (i.e. go into the kitchen & forget why)?			
11.	Have you experienced concentration issues?			
12.	Bothered by noise since the accident?			
13.	Have you experienced a temperament (mood) change?			
14.	Have you experienced a change in your sleep pattern?			
15.	Have you experienced balance issues?			
16.	Do you think more slowly than before the accident?			
17.	Do you experience difficulty reasoning and solving problems?			
18.	Have you experienced restlessness?			
19.	Have you experienced problems reading or listening since the accident?			
20.	Have you had problems paying attention since the accident?			
21.	Have you experienced issues with your attention span (distractibility)?			
22.	Have your math abilities been affected?			
23.	Have you experienced sexual dysfunction since the accident?			
24.	Have you experienced speech problems? (searching for words)			
25.	Has your diction been affected? (the choice and use of words)			

Part 2:

		No	Mild	Moderate	Severe
1.	Have you experienced depression since the accident?				
2.	Have you experienced anxiety since the accident?				
3.	Have you experienced a low frustration tolerance since the accident?				
4.	Have you experienced apathy (lack of interest) since the accident?				
5.	Have you experienced withdrawal from friends since the accident?				
6.	Have you experienced withdrawal from other social activities since the accident?				
7.	Have you experienced nightmares concerning the accident?				
8.	Have you experienced irritability and/or rages since the accident?				
9.	Have you experienced nervousness since the accident?				
10.	Have you experienced crying spells since the accident?				
11.	Have you experienced a lowered self-esteem since the accident?				

Part 3:

Did you hit any part of your body during the collision, for example, head on dash, chest on steering wheel?
(circle one) YES NO UNSURE

If yes, which part and how? _____

Where were you taken after the accident? (circle) Hospital / Urgent Care / Friends House / Parents House / Home
Other: _____

How did you get to the destination you were taken to? (circle)
Ambulance / Someone drove me / I drove myself / Other: _____

Were you hospitalized (stayed overnight)? (circle) YES NO Other: _____

If YES, for how long did you stay? _____

Did you receive care from a health care specialist? (circle) YES NO Other: _____

If YES, when did you receive care? (circle)
Immediately after the accident / a few days / a week / a few weeks / a month / Other: _____

If you received care from a health care specialist, what was their name?
_____ or I don't remember

Does it bother you to ride in a car now? YES / NO / SOMETIMES

If so, does it bother you as a Driver _____ Passenger _____

State any strange events that happened during or immediately after the accident _____

Have you had any time loss from work? YES / NO If yes, for how long? _____

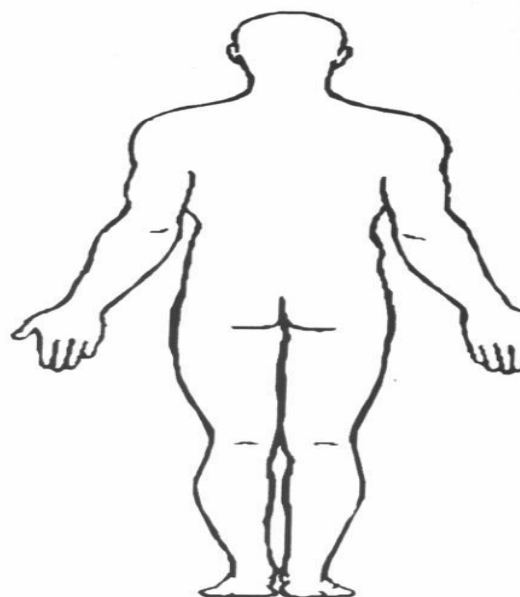
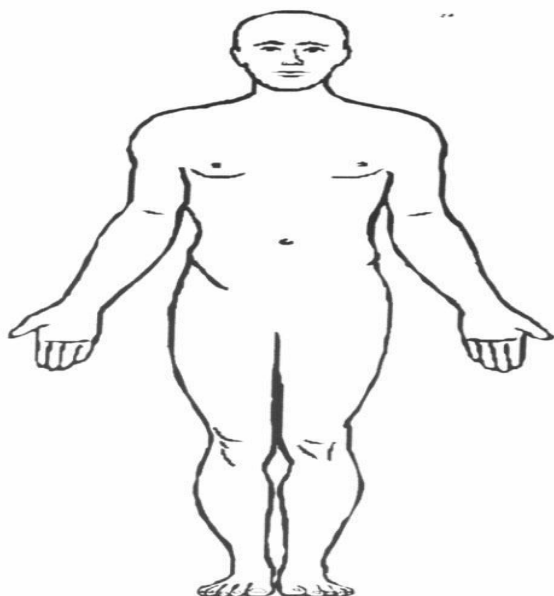
Have you had any outside help since the accident? YES / NO

If yes, what kind of help did you require after the accident? _____

PLEASE DRAW THE ACCIDENT

MARK PAIN AREA

+++	Burning	000	Stabbing
---	Sharp		Constant



General Pain Index Questionnaire

Please mark how much your pain presently **prevents** you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst. Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **Family at home responsibilities:** such as yard work, chores around the house or driving the kids to school

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

2. **Recreation:** including hobbies, sports or other leisure activities

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

3. **Social activities:** including parties, theater, concerts, dining out and attending other social functions

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

4. **Employment:** including volunteer work and homemaking tasks

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

5. **Self-care:** such as taking a shower, driving or getting dressed

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

6. **Life-support activities:** such as eating and sleeping

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

Patient name: _____ Patient #: _____

Signature: _____ Date: _____

ACCIDENT & INJURY ASSIGNMENT - AUTHORIZATION OF LIEN

NAME: _____

DATE: _____

I, the assignee, being the patient or legal guardian (for said minor listed below), do hereby irrevocably authorize, direct, assign and give full lien to the office of **MADISON HEIGHTS CHIROPRACTIC CENTER** (located at 28107 John R Rd, Madison Heights, Michigan 48071) hereinafter referred to as the "facility" against any & all insurance benefits, proceeds of any settlement of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the facility. I, the assignee further authorize any and all insurance company, case manager, attorney and any & all third party payers to pay directly to the facility **ALL** sums of money due to them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, injury, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. In the event that I retain one or more attorneys who receive(s) proceeds from one of more payers, I hereby direct (and the facility hereby requests) each attorney to provide immediate notice to the facility regarding such proceeds, to promptly pay the facility in-full out of such proceeds a full accounting of such proceeds to the facility. I agree that the purpose of such proceeds shall be primarily to pay my charges. If I have a dispute regarding the charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of proceeds to the facility. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "common fund doctrine" or other legal basis, to require the facility to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining proceeds. Assignee agrees that this facility & staff may process medical reports, deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance by me, and authorize this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal services bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INFORMED CONSENT

I understand that the facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur or I may get worse. I further understand that in the practice of medicine, chiropractic, psychological counseling & physical therapy there are some risks including but not limited to fractures, disc injuries, strokes, dislocations, sprains-sprains, drug interactions & reactions, including cardio-pulmonary arrest, death, and/or other injuries or side effects which cannot be predetermined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by the health care provider of this facility.

INSURANCE BENEFITS - PAYMENT TERMS & CONDITIONS

1. As a courtesy, the facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our facility & staff are **not** responsible for what a third party payer and/or representative may tell us. Any insurance contractual obligations or arrangements between you and an attorney or third party payer are between you and your insurance carrier and/or the third party payer.
2. Our facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.
3. Co-pays, deductibles and all non-covered service charges are your responsibility.
4. All account balances, including automobile and work injury claims must be paid in full within 60 days of treatment. Patients and/or legal guardians are fully responsible for all money owed and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within a 60-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A service charge is computed by a 'periodic rate' of 1 ½% per month - 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal action for which the undersigned agrees to be 100% responsible for all monthly service charges, cost related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debt & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$50.00 charge.

I acknowledge that I have read or have had read to me and understand all terms and conditions of this accident and injury assignment - authorization of lien as stated on this form and agree to all terms & conditions. A photocopy of this document shall be considered as effective and valid as the original.

Print Name of Patient

Signature (if minor, parent must sign)

Date



Madison Heights Chiropractic Center

IRREVOCABLE ESCROW INSTRUCTION AND AGREEMENT

The undersigned patient (hereinafter "Patient") in order to introduce The **MADISON HEIGHTS CHIROPRACTIC CENTER** located at 28107 John R Rd, Madison Heights, Michigan 48071 (hereinafter the "Provider") to extend credit to the patient, hereby irrevocable instruct my attorney and escrow agent, to pay to Provider the **FULL** amount of any bill for services rendered by the Provider, from the proceeds of my personal injury settlement or award within ten (10) days of receipt by him/her of same, excepting time for any negotiable instrument to clear.

This escrow instruction and agreement is irrevocable by me and is being used to include the Provider to provide continued medical services to me resulting from my accident.

Dated: _____

Patient Signature

Patient Name (Printed)

Patient Address

Understood and agreed to by:

Dated: _____

Provider Name

Provider Signature