Birks Chiropractic & Wellness Center

Auto Injury Patient Intake

Patient & Accident Information

First Name:_____ MI: ___ Last Name: _____Today's Date: _____

Address: _____City: _____State:_____Zip:_____

Home Phone: _(_____)_____-_____ Cell Ph: _(_____)_____-_____
Work Ph:_(_____)_____-_____ Email: _____

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements or promotions.

Birth Date: _____ Marital Status: _____ Occupation: _____
Employer:_____

Emergency Contact: _____ Phone:__(_____)_____-_____

Date of Accident: _____ Time of Accident:_____ AM / PM

Were you the: □ Driver □ Front Passenger □ Rear Passenger Make & Model of Car:_____

Did the police come to accident site? □ **YES** □**NO** Was a police report filed? □ **YES** □**NO**

Were you wearing a seat belt? □ **YES** □**NO** Did the airbags inflate? □ **YES** □**NO**

Did any part of your body strike anything in the vehicle? _____

What was the approximate speed of your vehicle?_____ Were you: □ aware □ surprised by the impact

Did the impact to your vehicle come from the: □ Front □ Rear □ Right Side □ Left Side □ Other_____

During impact were you facing: □ Right □ Left □ Forward □ Behind

Did accident render you unconscious? □ YES □NO If yes, for how long?_____

Current Problem

Describe Symptoms:

_____

_____

Pain scale (circle): 0 1 2 3 4 5 6 7 8 9 10
No Pain **Worst Pain**

What activities of daily living are affected? _____

For the following questions circle what is true for your condition

Have you ever had the same condition? **NO** **YES** If yes, when? _____
Does the pain radiate into your: **Arm** **Leg** **Other** **Doesn't radiate**
Do you experience numbness or tingling? **NO** **YES**
Did the pain come on **Gradually** or **Suddenly**?
Do you have a congenital (birth) condition? **NO** **YES** If yes, what is the condition? _____
What makes your symptoms worse? _____
What makes your symptoms better? _____
Previous treatments for this condition, including self-treatment?_____
Have you ever been under Chiropractic care? **NO** **YES**
What was the previous treatment for? _____

Auto Accident New Patient

Dr. Kara Birks, DC Dr. Linda Claeys, DC and Dr. Ariel Young, DC

CIRCLE "HAD" OR "HAVE FOR ANY THAT APPLY:

Musculoskeletal:
Had Have **Neck Pain**
Had Have **Back Pain**
Had Have **Muscle Weakness**
Had Have **Leg Cramps**
Had Have **TMJ Issues**
Had Have **Arm/Hand Pain**
Had Have **Broken Bones**
Had Have **Swelling of Joints**
Had Have **Osteoporosis**
Had Have **Scoliosis**

Neurological:
Had Have **Tremors**
Had Have **Dizziness/Fainting**
Had Have **Head Injury**
Had Have **Anxiety**
Had Have **Depression**
Had Have **Headache**
Had Have **Stroke**
Had Have **Numbness/Tingling**
Had Have **Balance Problems**
Had Have **Memory Confusion**
Had Have **Seizures**

Urinary:
Had Have **Pain with Urination**
Had Have **Difficulty Urinating**
Had Have **Frequent Infections**
Had Have **Blood in Urine**
Had Have **Incontinence**
Had Have **Kidney Infections**
Had Have **Urgency to Urinate**
Had Have **Water Retention**
Had Have **Bedwetting**
Had Have **Kidney Stones**
Had Have **Swelling**

Gastrointestinal:
Had Have **Changes in Bowel Habits**
Had Have **Changes in Appetite**
Had Have **Nausea**
Had Have **Heartburn**
Had Have **Anorexia/Bulimia**
Had Have **Diarrhea**
Had Have **Constipation**

Cardiovascular/Respiratory:
Had Have **High Cholesterol**
Had Have **High Blood Pressure**
Had Have **Low Blood Pressure**
Had Have **Emphysema**
Had Have **Pneumonia**
Had Have **Chest Pain**
Had Have **Excessive Coughing**
Had Have **Difficulty Breathing**
Had Have **Asthma**
Had Have **Irregular Heartbeat**
Had Have **Coughing up Blood**
Had Have **Poor Balance**
Had Have **Wheezing**
Had Have **Easy Bruising/Bleeding**

Endocrine:
Had Have **Thyroid Issues**
Had Have **Low Energy**
Had Have **Immune Disorders**
Had Have **Excessive Thirst**
Had Have **Frequent Urination**
Had Have **Diabetes**
Had Have **Frequent Sweating**
Had Have **Dry Skin**

Eyes:
Had Have **Blurred Vision**
Had Have **Cataracts**
Had Have **Dry Eyes**
Had Have **Glasses/Contacts**
Had Have **Itchy Eyes**
Had Have **Glaucoma**
Had Have **Eye Pain**

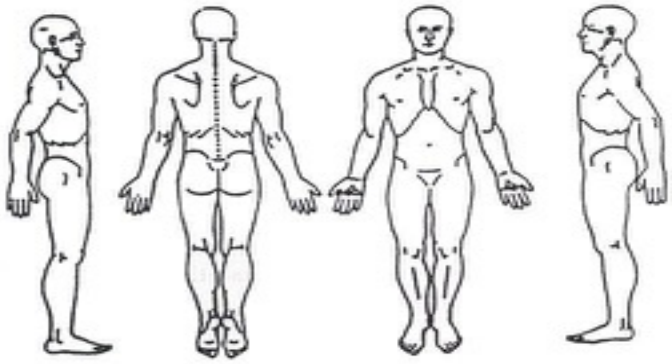
Integumentary/Skin:
Had Have **Skin Cancer**
Had Have **Psoriasis**
Had Have **Eczema**
Had Have **Allergy Shots**
Had Have **Rash/Hives**
Had Have **Hair Loss**

Ears:
Had Have **Hearing Loss**
Had Have **Ringing in the Ears**
Had Have **Chronic Ear Infections**

Nose:
Had Have **Loss of smell/ Pressure or Pain**
Had Have **Allergies**

Females/Males:
Had Have **Infertility**
Had Have **Irregular Cycles**
Had Have **Prostate Problems**
Had Have **Erectile Dysfunction**
Had Have **Hernia**

MARK AREAS OF CONCERN:



In order to provide you the best possible wellness care, please complete the form.
All information is strictly CONFIDENTIAL.

Auto Accident New Patient

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Medical History

Have you been treated for any conditions in the last year? **NO** **YES**
If yes, please describe _____
Date of last physical exam and Doctor_____
Women: Is there a chance that you are pregnant? **NO** **YES** Date of Last Menses: _____
Have you had X-rays or a MRI taken? **NO** **YES** If yes, where & when? _____

Medications _____
Allergies _____
Auto Accidents _____
Surgeries _____
Traumas/Other _____

Family History

Family Members - Present and past health conditions (Example: Heart disease, cancer, diabetes, arthritis, etc.)

Family Member: (ie.mother, father)	Condition:
_____	_____
_____	_____
_____	_____

I CERTIFY THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.
Signature:_____ Date: _____

Informed Consent for Care

You are the decision maker for your health care. This informed consent involves your understanding and agreement regarding the care we recommend the benefits and risks associated with the care, alternatives, the potential effect on your health if you choose not to receive the care and any of the fees for the services being provided to you by Birks Chiropractic and Wellness Center S.C.

Chiropractic care involves what is known as a chiropractic adjustment and possible additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing pain, swelling and inflammation in a joint, and improving neurological function and overall well-being. We may conduct chiropractic, physiotherapy, acupuncture, diagnostic or examination procedures if indicated that will be carefully performed but may be uncomfortable.

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It is important you understand, as with any health care approach, results are not guaranteed, and there is no promise to cure. As with all types of health care, there are some risks, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burn and/or scarring from electrical stim or cold therapies, broken bones, disc injuries, dislocations, strains and sprains and strokes.

With respect to stroke, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in normal, healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing and driving. Arterial dissection occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients, who experience the condition often, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1 million to 1 in 2 million cervical adjustments.

It is also important that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already and you have the right to a second opinion about your circumstances and health care as you see fit.

I understand that if I am accepted as a patient by Birks Chiropractic and Wellness Center S.C., I have read, or have had read to me, the above consent. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that I am financially responsible for all services rendered to me or my dependent at Birks Chiropractic and Wellness Center SC. I hereby authorize Birks Chiropractic and Wellness Center SC to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf, I understand that I am financially responsible for any remaining balance. I further authorize my insurance company to direct payment to Birks Chiropractic and wellness Center SC on my behalf.

I authorize the physician to diagnose and treatment or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan. I understand that results are not guaranteed. I am authorizing them to proceed with any treatment that may be necessary. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance for which I seek chiropractic care from Birks Chiropractic and Wellness Center S.C.
Signature of Patient or Legal
Guardian:_____Date:_____

Printed Patient Name: _____

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