MARS HILL CHIROPRACTIC CENTER

PERSONAL INJURY / MOTOR VEHICLE ACCIDENT

Patient: ____ D.O.B. ________________ Date: ________________

1. Date and Time of Accident: ________________
2. Were you the: O Driver O Front passenger O Rear passenger
3. If a traffic violation was issued, to whom was it issued? ____
4. Number of people in your vehicle? ______
5. Did the police come to the accident site? O Yes O No Was a police report filed? O Yes O No
6. Were there any witnesses? O Yes O No
7. Did airbags inflate? O Yes O No
8. Were you wearing a seatbelt? O Yes O No
9. Make and model of the vehicle you were occupying? ________________
10. Location where the accident occurred? ________________________
11. The headrest was: O Below the base of skull or O Behind the head
12. Did any part of your body strike anything in the vehicle? O Yes O No If yes, what? ________________
13. What was the approximate speed of your vehicle? ________________
14. Did the impact to your vehicle come from the: O Front O Rear O Right side O Left side
15. During impact, were you facing? O Right O Left O Forward
16. Did you know the accident was about to happen? O Yes O No
17. Make and model of the other vehicle?____________________ Speed of the other vehicle? ______________
18. In your own words, please describe the accident: ____
    ____
19. Did the accident render you unconscious? O Yes O No
20. Did you go to the hospital? O Yes O No
21. Describe any exam and treatment you received: ____
22. Have you been on medication due to the accident? O Yes O No If yes, what medications? ______________
23. Have you had to miss work since the accident? O Yes O No
24. Indicate the symptoms that are a result of this accident?

O Dizziness	O Difficulty Sleeping	O jaw problems	O Nausea
O Memory loss	O Irritability	O Arms / shoulder pain	O Back pain
O Headaches	O Fatigue	O Numb hands / fingers	O Low back pain or stiff
O Blurred Vision	O Tension	O Chest Pain	O Leg pain or numbness
O Buzzing in ear	O Neck pain or stiff	O Shortness of breath	O Other____________

25. Have you retained an attorney? O Yes O No
26. Activities that have been limited since the accident? (include loss of sleep, bending, lying down, sitting, reading, Running, etc) ____
    ____

Patient Signature ____ Date____________________________

Welcome to
Mars Hill Chiropractic Center

342 Carl Eller Road Mars Hill, NC 28754
Telephone # (828) 689-3777
Fax # (828) 689-5435

Today's Date:______________________________

Full Name:______________________________

Name you prefer to be called:________________

Birthdate:____________________**Age:**________

Address:______________________________

____

Cell Phone:______________________________

Home Phone:______________________________

Work Phone:______________________________

Email:______________________________

Employer:______________________________

Occupation:______________________________

Marital Status(circle): **single married divorced widowed**

# of children:____________**Ages:**____________

Referred by:______________________________

Work Status:______________________________

Medical Doctor:______________________________

Practice Name:______________________________

(example: Mars Hill Medical Center)

Emergency Contact Peron:____________________

Emergency Contact #:______________________

Relationship to you:______________________

Is your pain or injury the result of an accident? _______YES _____NO

If yes, was it: ______ auto accident ______injury ______accident at work

Please read and initial:

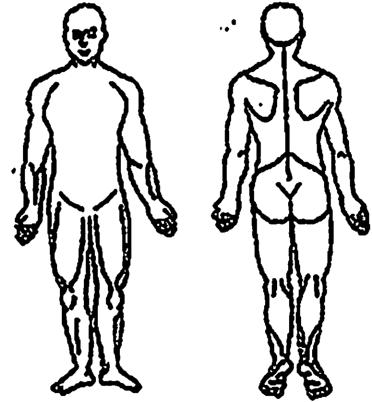
______We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.

______ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. If account is not paid within 90 days of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collection of your account.

______ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status or any changes to the information I have provided on this form.

Signature:______________________________ **Date:**______________________________

Patient:__________________ **D.O.B.**______________ **Date:**________________



1. Name your **PRIMARY** complaint and **indicate on diagram** where your pain is:______________________________
2. Pain is: **Sharp Dull Burning Throb Stabbing Numb Ache Other**
3. When did your symptoms start?______________________
4. How did your symptoms start?______________________
5. Average pain intensity:
   in the last 24 hours: no pain 1 2 3 4 5 6 7 8 9 10 worst pain
   in the past week: no pain 1 2 3 4 5 6 7 8 9 10 worst pain
6. How often do you experience your symptoms? (circle below)
   Constantly (75-100% of the time) **Frequently (50-75% of the time)**
   Occasionally (25-50% of the time) **Intermittently (0-25% of the time)**
7. How are your symptoms changing? (circle below)
   Getting better **Not changing** **Getting worse**
8. What make your symptoms worse?______________________________
9. What made your symptoms better?______________________________
10. Have you had this problem examined by anyone else?______________________
11. What have you done to treat this problem?______________________

Additional Complaints:______________________________________

____

List current medications, including dosage: If there are no current medications, check here: **O**

1. ______________________	**7.**______________________
2. ______________________	**8.** ______________________
3. ______________________	**9.** ______________________
4. ______________________	**10.**______________________
5. ______________________	**11.** ______________________
6. ______________________	**12.** ______________________

List any known allergies you have had to medications, if applicable:______________________

____

Has your doctor diagnosed you with high blood pressure presently? **O Yes** **O No**

Has your doctor diagnosed you with diabetes presently? **O Yes** **O No** if yes, what kind? **Type 1** **Type 2**

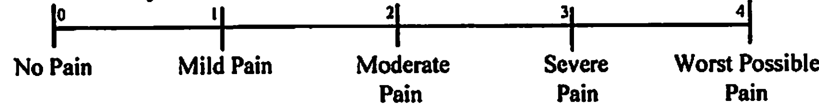
Have you had an x-ray, CT scan or MRI of your spine in the past 28 days? **O Yes** **O No**

Mars Hill Chiropractic Center

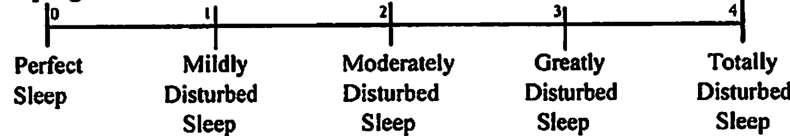
Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

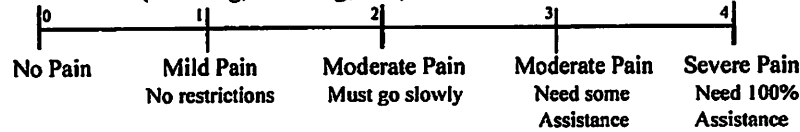
1. Pain Intensity



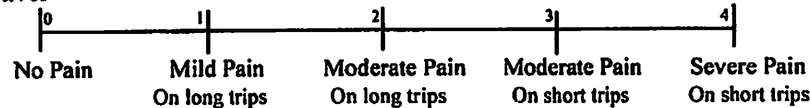
2. Sleeping



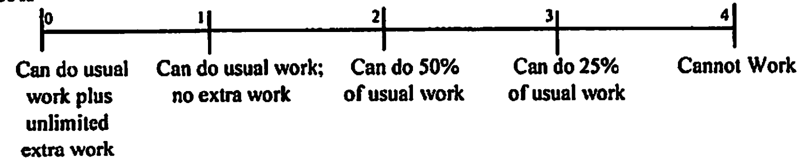
3. Personal Care (washing, dressing, etc.)



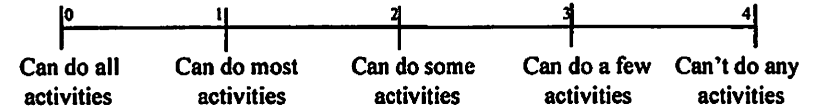
4. Travel



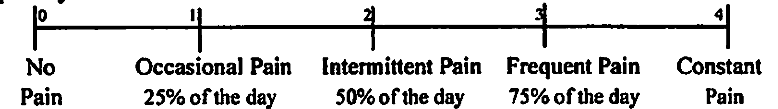
5.Work



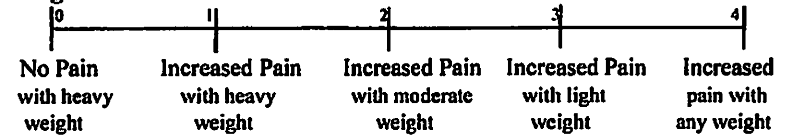
6. Recreation



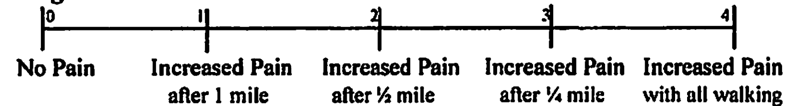
7. Frequency of Pain



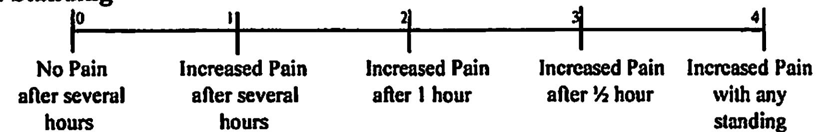
8. Lifting



9. Walking



10. Standing



Patient Name: ______________________________

Signature: ______________________________ **Date:** ____________________

Patient Health Questionnaire

Patient Name: ______________________________ **Date:** ____________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet, Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/Upper Leg Pain
O	O	Knee/Lower Leg Pain
O	O	Ankle/Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/Stiffiness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness

Past	Present	Condition
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Ulcer
O	O	Hepatitis
O	O	Liver/Gall Bladder Disorder
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitis

Past	Present	Condition
O	O	Diabetes
O	O	Excessive Thirst
O	O	Frequent Urination
O	O	Smoking/Use Tobacco Products
O	O	Drug/Alcohol Dependence
O	O	Allergies
O	O	Depression
O	O	Systemic Lupus
O	O	Epilepsy
O	O	Dermatitis/Eczema/Rash
O	O	HIV/AIDS
Females Only		
O	O	Birth Control Pills
O	O	Hormonal Replacement
O	O	Pregnancy
O	O	
Other Health Problems/Issues		
O	O	
O	O	
O	O	

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O________________

List all the surgical procedures you have had and any times you have been hospitalized:

____

____

Any other health concerns the doctor should know:

____

____

Patient Signature: ______________________________ **Date:** ____________

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which Mars Hill Chiropractic Center may have to see or use your health care information. We may have to disclose your health information:

- To another health care provider for referral to them for treatment or diagnosis
- To an insurance company or another party if the are responsible for payment of your services for treatment
- Amongst the staff within our practice for quality control or administrative purposes

Your right to limit uses or disclosures

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Mars Hill Chiropractic Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mars Hill Chiropractic Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Patient Name: ___________________________________

Signature: _____________________________________ Date: _______________

Informed Consent to Chiropractic Care

We provide adjustments, or manual manipulations, through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasms, loss of mobility, headaches, and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations, and fractures. In addition:

- While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscle and ligament strains or sprains as a results of manual therapy techniques.
- There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustments and the occurrence of stroke.
  - The apparent associated is noted very infrequently, however, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
- There are reported cases of disc injury following a cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, or medical treatments and surgery provided by physicians and surgeons.

Dry needling is a technique that utilizes thin, solid filament needles. This needling technique is used specially to treat myofascial trigger points, muscle spasms, or dysfunctional tissue. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur. They include pain, infection, bruising or bleeding, drowsiness, fatigue and autonomic responses, and pneumothorax.

By signing this informed consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks, and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care received from Mars Hill Chiropractic Center.

Patient Printed Name: ______________________________

Patient Signature: ______________________________

Legal Guardian Signature: ______________________________

Witness Signature: ______________________________ Date: ____________

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFTIS

IN CONSIDERATION of the willingness of **MARS HILL CHIROPRACTIC CENTER** to treat me on credit without demand for payment at the time services are rendered. I hereby agree and stipulate as follows:

I irrevocably assign to Mars Hill Chiropractic Center any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on ____________________ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to **MARS HILL CHIROPRACTIC CENTER**, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, judgments, settlements, or proceeds of any kind that would be otherwise be payable to me, such sums are due to **MARS HILL CHIROPRACTIC CENTER** for its service rendered.

I appoint **MARS HILL CHIROPRACTIC CENTER** as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named a payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with **MARS HILL CHIROPRACTIC ENTER.**

I authorize **MARS HILL CHIROPRACTIC CENTER** to release any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to **MARS HILL CHIROPRACTIC CENTER** for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If **MARS HILL CHIROPRACTIC CENTER** is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse **MARS HILL CHIROPRACTIC CENTER** for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient____

Date____

Witness____

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49, **MARS HILLCHIROPRACTIC CENTER** hereby asserts and gives notice of a lien upon any sums recovered in damage for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

MARS HILL CHIROPRACTIC CENTER hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. **MARS HILL CHIROPRACTIC CENTER** agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

CLINIC NAME BY:_______________________________________**DATE:**__________________________

Mars Hill Chiropractic Center
Dr. Lawrence R. Smith Dr. Stephen Canner
Dr. Jason Leonard Dr. Jackie Leonard
342 Carl Eller Road
Mars Hill N.C. 28754
(828) 689-3777 Fax: (828) 689-5435

PERSONAL INJURY INSURANCE INFORMATION FORM

PATIENT'S AUTO INSURANCE

Name of Insured____________________
Insurance Co.____________________
Address of Co.____________________
____
____
Name of Agent____________________
Phone Number____________________
Policy Number____________________

AUTO INSURANCE OF OTHER PERSON INVOLVED IN THE ACCIDENT

Name of Insured____________________
Insurance Co.____________________
Address of Co.____________________
____
____
Name of Agent____________________
Phone Number____________________
Policy Number____________________

PATIENT'S HEALTH INSURANCE

Name of Insured____________________
Insurance Co____________________
Address of Co.____________________
____
____
Policy Number____________________
Name of Employer____________________
Address of Employer____________________
____

ATTORNEY NAME:____________________ **PHONE#**____________________
FIRM:____________________
ADDRESS:____________________
____
FAX#:____________________ **EMAIL:**____________________