

DIMOND CHIROPRACTIC

Date: _____

PT NUM # _____

Name: _____

First

MI

Last

Physical Address _____ City, State, Zip: _____

Mailing Address _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex ___ M ___ F Birth date: _____ Age ___ Driver's License # & State: _____

SSN: _____ **Check one:** ___ Married ___ Single # of children: _____

Employer: _____ Occupation: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

Who can we thank for referring you to our office: _____

Reason for consulting this office: _____

Is this injury due to a work or auto accident? _____ Date of Injury: _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance Company: _____ Phone Number _____

Subscriber: _____ Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group# _____

Secondary Insurance Company: _____ Phone Number _____

Subscriber: _____ Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group# _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents. I also authorize Dimond Chiropractic Center to release any information required to process my claims. I also hereby authorize Dr. Shawn Woodmansee and whomever he may designate as assistants to administer care as deemed necessary.

Patient/Guardians Signature _____

Privacy Practices

I have been offered the Notice of Privacy Practices and I have been provided an opportunity to review it if needed.

Patient Name _____

Signature _____

Date of Birth _____

Date _____

FINANCIAL POLICY

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED: As a courtesy to our patients, we do allow other payment options within the guidelines of our office policy.

CASH: We accept cash, check, Debit, Visa, MasterCard, Discover and American Express. Payment for service is due at the time services are rendered, unless payment arrangements have been approved in advance. Returned checks are subject to a \$15.00 service charge.

GROUP INSURANCE: Patients are responsible for payment in full at the time of visit, unless our office is able to verify chiropractic benefits. Dimond Chiropractic Center checks your benefits with the insurance companies; understand that the benefits quoted are neither a guarantee of payment nor a guarantee of benefits. They are subject to eligibility, deductible and available benefits are the time services are rendered. As a courtesy to you, we will submit all charges to your insurance company. It is important that you understand that your insurance is an arrangement between you and your insurance company. We do not bill Medicare insurance. You're personally responsible for payment of all charges, whether your insurance company pays or not. Co-pays are due at the time services are rendered, unless payment arrangements have been approved in advance.

WORKERS' COMPENSATION: Patients are required to fill out a **REPORT OF OCCUPATIONAL INJURY OR ILLNESS** with their employer. Once this is completed and verification has been made with the insurer, we will accept assignment.

ACCIDENT AND PERSONAL INJURY (AUTO): Patients are responsible for payment in full at the time of each visit unless our office is able to verify the claim number and Medical Payment coverage for the accident/injury. We do not bill third party insurance. If during the course of your treatment here your medical coverage is exhausted, payment arrangements must be made to keep your account current. If an attorney is retained, please let our office know immediately.

If you have any questions or comments regarding our policy, we will be happy to assist you.

Patient's Signature

Date

Representative of Dimond Chiropractic Center

Date

Dimond Chiropractic Center

Informed Consent for Chiropractic Treatment

Doctors of chiropractic, medical doctors, and physical therapist who use manual therapy are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

- A) While rare, some patient have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
- B) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with neurological impairment, and may on rare occasion results in serious injury. The possibility of such injuries resulting from cervical spine adjustment is extremely remote;
- C) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or spinal treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributed to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Print Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Dimond Chiropractic, LLC

Patient Name: _____ Date: _____

Please review the following list of medical problems and mark any that apply to you now or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

Constitutional

- Recent weight gain: _____ lbs
- Recent weight loss: _____ lbs
- Fever or soaking sweats at night
- Fatigue
- Weakness/numbness of arms/legs
- Headaches > 2 times per week
- Difficulty walking
- Loss of consciousness/convulsions

Eyes

- Vision problems not corrected by glasses
- Glaucoma
- Eye lens implant
- Eye prosthesis
- Contact lenses

Ear, Nose, Throat

- Chronic stuffy nose or nasal polyps
- Frequent nose bleeds
- Sinus problems
- Hay fever allergies
- Difficulty hearing
- Ear infections
- Hearing aids
- Chronic sore throat or tonsillitis
- Hoarseness
- Difficulty swallowing
- Dentures or partial plates
- Capped teeth
- Loose teeth
- Orthodontic braces

Cardiovascular

- Heart murmur
- Prolapsed mitral valve
- Heart pacemaker
- Irregular heartbeat
- Palpitations or rapid pulse
- Fainting spells
- Chest pain or angina on exertion
- Chest pain or angina at night
- Heart attack
- Congestive heart failure
- Swelling in feet or ankles
- Shortness of breath lying flat
- Shortness of breath at night
- Blood Clots or pulmonary embolism

- High blood pressure

- Low blood pressure

Respiratory

- Asthma or wheezing
- Bronchitis
- Emphysema
- Pneumonia
- Chronic cough
- Change in amount of phlegm
- Change in color of phlegm
- Coughing up blood
- Collapsed lung
- Tuberculosis exposure
- Blueness of your fingernails

Gastrointestinal

- Kidney stones
- Kidney infections
- Kidney failure
- Dialysis
- Prostate problems
- Bladder infections
- Blood in urine
- Difficulty urinating
- Do you lose your urine at times

Musculoskeletal

- Fractures or broken bones
- Arthritis
- Difficulty opening mouth wide
- Scoliosis
- Spinal column deformity

Integumentary/Dermatologic

- Skin rash or sores
- Itching
- Color change, pigmentation, nodules
- Pressure ulcers

Neurologic

- Seizures or convulsions
- Epilepsy
- Stroke
- Brain aneurysm or hemorrhage
- Multiple sclerosis
- Nerve Injury or numbness

Psychiatric

- Depression
- Anxiety or panic attacks
- Mental disorder

Endocrine

- Diabetes
- Insulin use
- Low blood sugar or hypoglycemia
- Thyroid problems
- Steroid use

Allergic/Immunologic

- Herpes exposure
- AIDS exposure
- Street drug use

Hematologic

- Abnormal bleeding problems
- Anemia or low blood count
- Blood transfusion
- Hemophilia
- Sickle cell anemia

Lymphatic

- Swollen glands or masses in axillae, groin
- Lymphedema

Others

- Sexual problems
- Muscular dystrophy
- Myasthenia gravis
- Malignant hyperthermia
- Bad reaction to local anesthetic
- Down Syndrome
- Cancer or tumor
- Chemotherapy
- Radiation Therapy
- Recent acute illness
- Recent hospitalization
- Recent Surgical operation

For Women Only:

Are you pregnant? Yes No

Are your menstrual periods normal?

Yes No

Bleeding between periods

Bleeding after menopause

Number of pregnancies: _____

Date of last menstrual period: _____

Approx date of last pap smear: _____

Reviewed by: _____ Date: _____

Activities of Daily Living Assessment

Rate your current difficulties resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most clearly describes your current degree of difficulty.
1= "I can do it without any difficulty." **2=** "I can do it without much difficulty." **3=** "I manage to do it by myself, despite marked pain." **4 =** "I manage to do it despite the pain, but only if I have help." **5=** "I cannot do it all, because of the pain." **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities											
Bathing		Drying hair		Brushing teeth		Putting on Shoes		Preparing meals		Taking out trash	
Showering		Combing hair		Making bed		Tying Shoes		Eating		Doing laundry	
Washing Hair		Washing Face		Putting on shirt		Putting on pants		Cleaning Dishes		Going to toilet	
Difficulties and Physical Activities											
Standing		Walking		Kneeling		Bending back		Twisting left		Leaning back	
Sitting		Stooping		Reaching		Bending Left		Twisting right		Leaning left	
Reclining		Squatting		Bending Forward		Bending right		Leaning forward		Leaning right	
Standing for long periods		Sitting for long periods		Waking for long periods		Kneeling for long periods					
Difficulties with Functional Activities											
Carrying small objects		Lifting weights off floor		Pushing things while seated		Exercising upper body					
Carrying large objects		Lifting weights off table		Pushing things while standing		Exercising lower body					
Carrying brief case		Climbing stairs		Pulling things while seated		Exercising arms					
Carrying large purse		Climbing inclines		Pulling things standing		Exercising legs					
Difficulties with social and Recreational Activities											
Bowling		Jogging		Swimming		Ice Skating		Competitive sports		Dating	
Golfing		Dancing		Skiing		Roller Skating		Hobbies		Dining out	
Difficulties with Traveling											
Driving a motor vehicle		Riding as a passenger in a motor vehicle		Riding as a passenger on a train							
Driving for long periods of time		Riding as a passenger on an airplane		Riding as a passenger for long periods							

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

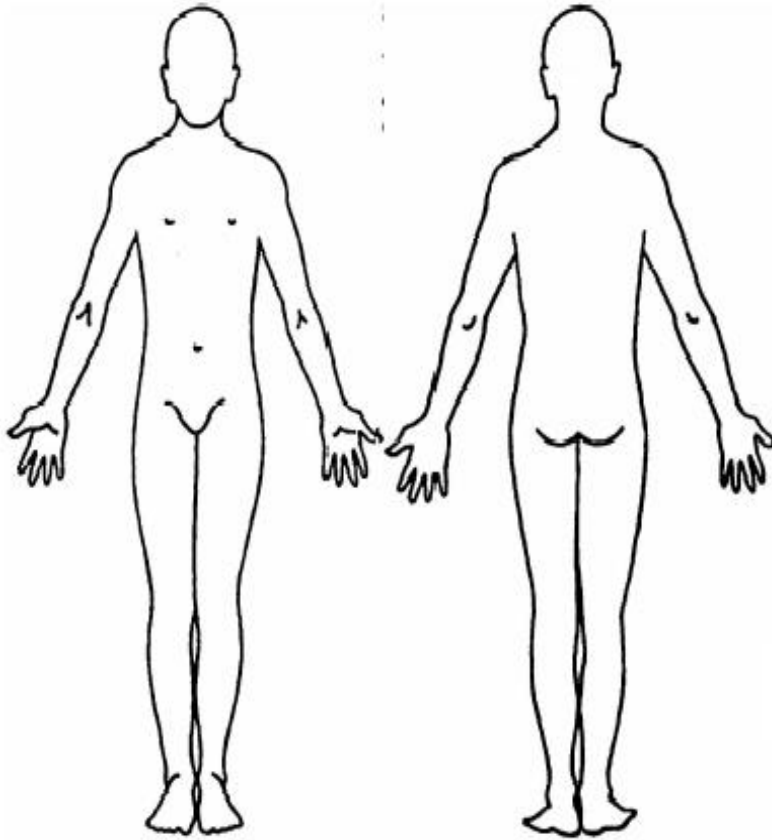
Prior Similar Symptoms <input type="checkbox"/> I have not had prior symptoms similar to my current complaints <input type="checkbox"/> My current complaints DID exist before, but have not been bothering me <input type="checkbox"/> My current complaints ALREADY existed and were worsened	Has your history contributed to your current symptoms? <input type="checkbox"/> My history HAS contributed to my current symptoms. <input type="checkbox"/> My history HAS NOT contributed to my current symptoms. <input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms
My most recent prior symptoms (if applicable) occurred ___ months ago / years ago Or on: Date ____/____/____	
Write in below any other Prior Symptom History, not covered above:	

Patients Signature: _____ Date: _____

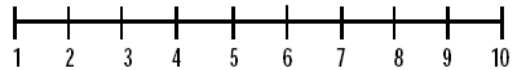
Name: _____ Date: _____

PAIN DIAGRAM

The information you provide on this form will be useful to Dr. Shawn and will help your exam go smoothly . If you are being evaluated for a painful condition, mark the drawings below according to how you feel today. Use the figure labeled "Back" for the pain on the back of your body. If you have any of the symptoms shown in the diagram, indicate where they are by writing in the following letter in the affected area. Please mark the level of pain you experiencing on the 1 to 10 scale. Ten as being the worst and one being no pain



BURNING = B
STABBING = S
PINS & NEEDLES = P
ACHING = A
NUMBNESS = N



MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

2. Phone Number: _____

3. Please describe the collision in your own words:

4. Where did the collision occur? City/Town: _____ State: _____

5. Date of collision: _____ Time: _____ AM PM

6. Were you the: driver passenger pedestrian

7. If passenger, were you in the front seat right rear seat left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? yes no

11. Was your car struck by the other vehicle? yes no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: the front the rear the left side the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? dry wet icy

17. Was your vehicle in: park neutral in gear moving stopped

18. Were your brakes being applied? yes no
19. Was your vehicle shoved: forward backward sideways
20. Were you shoved: forward whipped backward
21. Did your seat have a head restraint (headrest?) yes no
22. If yes, what was the position low midposition high
23. Did your head ride over the headrest? yes no
24. Did your hat/glasses end up in the back seat or rear window? yes no
25. Did any other part of your body hit the interior of the vehicle? yes no
26. If yes, please specify: seatbelt restraints steering wheel dashboard
 windshield side door side window other _____
27. Which part of your body? chest head chin face R L knee
 R L shoulder R L hand other _____
28. Were you holding on to the steering wheel? yes no
29. Did you brace your arms against the dash? yes no
30. Did you brace your legs against the floorboard? yes no
31. Was your ankle turned? yes no
32. Did the vehicle go into a spin or roll as a result of the impact? yes no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? none some a lot
35. How much damage was there to the inside of the vehicle? none some a lot
36. At the point of impact, where did you experience pain? Be specific:

37. Immediately after the accident were you: conscious dazed unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? yes no
40. Did the belt have a shoulder harness? yes no

41. If yes, did it contribute to the pain you are experiencing? yes no

42. At the time of impact were you: looking straight ahead looking to the right

looking to the left looking down looking up

43. Did the seat break as a result of the impact? yes no

44. Were you braced for the impact? yes no

45. Were you surprised by the impact? yes no

46. Did you go to the hospital? yes no

47. If yes, when? right after the accident next day other _____

48. If yes, how did you get there? ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? yes no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

52. Have you had any similar problems before? yes no

53. If yes, explain: _____

54. Are you diabetic? yes no

55. Do you have high blood pressure? yes no

56. Do you have low blood pressure? yes no

57. Do you have arthritis or degenerative joint disease? yes no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? yes no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? yes no

Name of adjuster handling claim _____

Will company accept assignment of benefits? yes no

If not, will they make checks payable to patient and our office? yes no

Limits: How much? \$ _____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? yes no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? yes no

In the event of settlement, will they protect any unpaid balance? yes no

Do they have PIP? yes no Do we file? yes no

Do they have insurance? yes no Do we file? yes no

Can we file liability? yes no