

Healthy Moose Chiropractic

Today's Date: ____/____/____ Date of Birth ____/____/____

Patient Name: _____

LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____ Work Phone# _____

CellPhone #: _____ E-mail Address: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

Referred to our office by: _____

Occupation: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

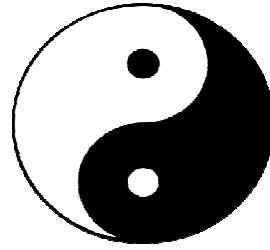
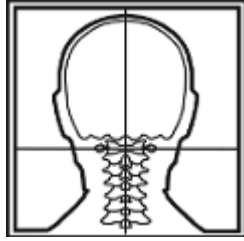
IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ M.D.'s Phone # _____



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Personal Injury / Attorney Lien / Workman’s Comp Cases

Each case requires a Lien. This enables our office to provide treatment and services for you, without payment at time of service. This means that our office will receive payment at the end of your case, not necessarily at the end of treatment. Because of this severe time lag in payment there is not a discount offered for services provided. Reductions in payment will be negotiated by your attorney and our office.

Date of Accident _____ What Kind of Accident? Auto / Motorcycle / Work Comp.

Do you have an attorney? Y N

If Yes who is your attorney _____

Do you have a personal injury doctor or work comp doctor? Y N

If Yes who is your doctor _____

Personal Injury - Your Accident – Please Circle or Write in your answer

What did you do, where did you go after the accident? Hospital, Work, Home, Other _____

Did the police come to the scene? Y N Was a police Report filed? Y N

Was anyone else in the car with you? Y N Names _____

Where were **you** in the accident? **Driver, Passenger - front, Passenger – back, Pedestrian**

Were you wearing a seat belt? Y N What kind? **Shoulder harness / Lap belt only**

What kind of vehicle (make, model, year) were **you** in? _____

What other kind of vehicle was involved in the accident? _____

Have you seen any other doctors or providers since your accident? Y N If Yes who _____

Were you employed when the accident occurred? Y N Are you employed now? Y N

Were you at work or working when the accident occurred? Y N

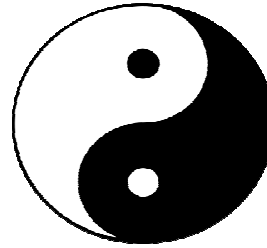
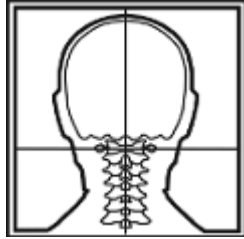
Did you have any pain or symptoms after the accident? Y N If No When? _____

Have you ever had any similar symptoms or pains like you have from the accident? Y N

Have you ever had surgery? Y N Have you ever been rated for a disability? Y N

Any previous Work Comp injuries? Y N Any previous serious illness? Y N

Any previous fractures or hospitalizations? Y N Any previous auto accidents? Y N



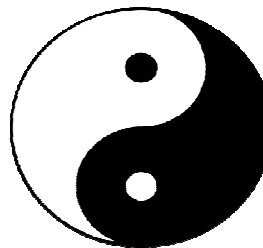
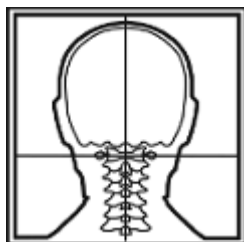
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Auto Crash Diagram

Please sketch out the accident to the best of your ability. Circle or Answer the questions below as best you can – estimate if you don't know the exact answer. There can be more than one answer for some questions.

How fast were you going? _____
 How fast was the other car going? _____
 Was this a **Rear** or **Frontal** or **Side** crash?
 Did the airbag deploy? **Y N**
 Were you prepared for the accident? **Y N**
 Where were you looking at the time of the accident?
Straight – Left – Up – Down – Right – Other _____
 What was your body position at the time of the accident?
Straight – Leaning Forward – Turned Right – Turned Left
 Was the seat back position altered from the accident? **Y N Unsure**
 Was the head rest position altered from the accident? **Y N Unsure**
 Where were your hands at the time of the accident?
Two hands on wheel – One on Wheel – None on Wheel
 Did any part of your body strike the vehicle? **Y N** _____
 Were the brakes applied at the time to the accident? **Y N**
 What time was the accident? _____ **AM / PM**
 Where you wearing a hat or glasses? **Y N** Remained on? **Y N**
 Did you lose consciousness? **Y N**
 Your vehicle damage appearance **Mild-Moderate-Heavy-Severe**
 Estimated damage \$ amount to your vehicle \$ _____
 Other vehicle damage appearance **Mild-Moderate-Heavy-Severe**

If you were taken to the ER – were any x-rays taken? **Y N** Other types of films (MRI, CT)? **Y N Unsure**
 What body parts did they taken films of? _____
 Any Lab work performed? **Y N** Were you given a cervical collar? **Y N** Were you given any Ice? **Y N**
 What medications if any were you given? _____
 What if any were the follow up instructions for your ER visit? _____



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- Do you have vertigo (dizziness)? Yes _____ No _____
- Do you pass out easily (faint or loss of consciousness)? Yes _____ No _____
- Do you have double vision or have you lost sight in one eye? Yes _____ No _____
- Do you have any slurred speech or difficulty with speech? Yes _____ No _____
- Do you have any difficulty walking, with coordination or falling to one side? Yes _____ No _____
- Do you have nausea or vomiting? Yes _____ No _____
- Do you have numbness on one side of your face or body? Yes _____ No _____
- Do you have any visual disturbances or rapid eye movement? Yes _____ No _____
- Do you have or have you ever had difficulty in arranging words properly? Yes _____ No _____
- Do you have a headache or head pain that is unlike any you have had before? Yes _____ No _____
- Do you have headaches for hours or days? Yes _____ No _____
- Do you have a history of stroke in your family? Yes _____ No _____
- Do you have chest pain? Yes _____ No _____
- Have you ever had cancer? Yes _____ No _____
- Does your jaw pop? Yes _____ No _____
- Do you grind your teeth at night? Yes _____ No _____
- Are you a restful sleeper? Yes _____ No _____
- Do you sleep on your stomach primarily? Yes _____ No _____
- Does your pain ever wake you from a sound sleep? Yes _____ No _____
- Are you losing weight without trying? Yes _____ No _____
- Are you coughing up blood or noticing it in your stools or urine? Yes _____ No _____
- Do you have indigestion or difficulty swallowing? Yes _____ No _____
- Do you have any change in bowel or bladder habits? Yes _____ No _____
- Do you have a sore that does not heal? Yes _____ No _____
- Do you have any unusual bleeding or discharge? Yes _____ No _____
- Do you have any thickening in your breasts or elsewhere? Yes _____ No _____
- Do you have a change in any wart or mole? Yes _____ No _____
- Do you have a nagging cough or hoarseness? Yes _____ No _____
- Do you have night sweats? Yes _____ No _____
- Do you have pain in neck, jaw or face? Yes _____ No _____
- Do you have a drooping eyelid or change in your pupils? Yes _____ No _____
- Do you have any ringing in your ears? Yes _____ No _____
- Do you take birth control pills? Yes _____ No _____
- Are your cycles regular (28-30 days)? Yes _____ No _____

What prescription medication are you taking if any?

[] High blood pressure [] Blood thinners [] Anti-depressants [] Herb, vitamins, or over the counter products

Other _____

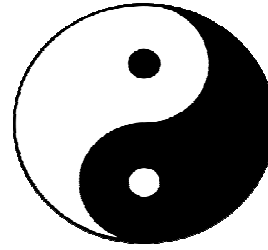
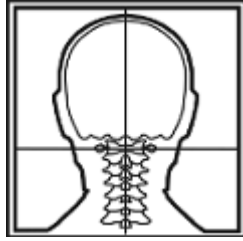
- Have you had any loss of bladder or bowel control? Yes _____ No _____
- Have you lost consciousness or had double vision recently? Yes _____ No _____
- Are you seeing any other doctor now for any reason? Yes _____ No _____

For what condition: _____

TOBACCO Yes _____ No _____ If Yes, how often _____

ALCOHOL Yes _____ No _____ If Yes, how often _____

COFFEE Yes _____ No _____ If Yes, how many cups _____



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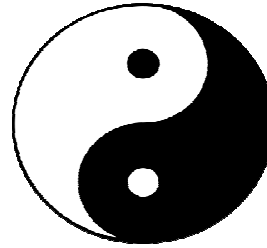
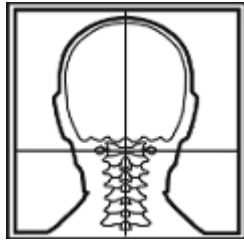
Whiplash and Accident Specific Symptoms and Questions

Please check if any of the following apply to you since your accident:

- | | |
|---|--|
| Blurred vision _____ | Double Vision, especially when tired _____ |
| Impaired reading ability _____ | Memory difficulty _____ |
| Daily Headaches _____ | Comprehension difficulty _____ |
| Sensitivity to light _____ | Impatient or Irritable easily _____ |
| Cannot concentrate _____ | Eyes hurt _____ |
| Eyes are tired, always want to close them _____ | Clumsy _____ |
| Difficulty with driving _____ | Double vision when driving _____ |
| Disorientation at times _____ | Pain in neck _____ |
| Pain in back _____ | Difficulty with focus _____ |
| Headaches when reading _____ | Blood shot eyes _____ |
| Easily loses place when reading _____ | Dizziness _____ |
| Vision periodically blacks out _____ | Easily tired by afternoon or evening _____ |

Please check if any of the statements below apply to you since your accident:

- I experienced something traumatic that I felt was life threatening to me _____
- I witnessed something traumatic that I felt was life threatening to me _____
- I see images or memories that I feel are painful to me _____
- I have recurring thoughts that seem to take over me so that I can't focus on what I need to focus on, or the thoughts repeat over and over and I can't make them stop _____
- I feel like the incident is happening to me over and over in the present _____
- I find that certain things remind me of the incident and it upsets me _____
- Sometimes I feel myself sweat, shake or I have difficulty breathing when I think of the incident _____
- I spend time avoiding anything that could possibly remind me of the incident _____
- I try not to talk about the incident because it is too difficult to talk about _____
- I feel like I don't enjoy anything in my life anymore _____
- It's hard to feel close to my family or friends. I tend to feel all alone most of the time _____
- I find it difficult to feel my feelings, and everything feels flat _____
- Sometimes I feel like my life will end soon _____
- I have trouble falling asleep or staying asleep _____
- I tend to get irritated easily and burst out in anger easily _____
- I have trouble recalling different aspects of the incident _____
- I feel as if I have a limited future, like I won't have a career, marriage or children _____
- I feel like I'm on edge _____
- I get easily distracted _____
- I find little joy in the things I do _____
- I can't relax. I must stay alert at all times _____
- I am easily startled. _____
- I have nightmares _____
- I find it hard to concentrate on whatever I'm doing _____

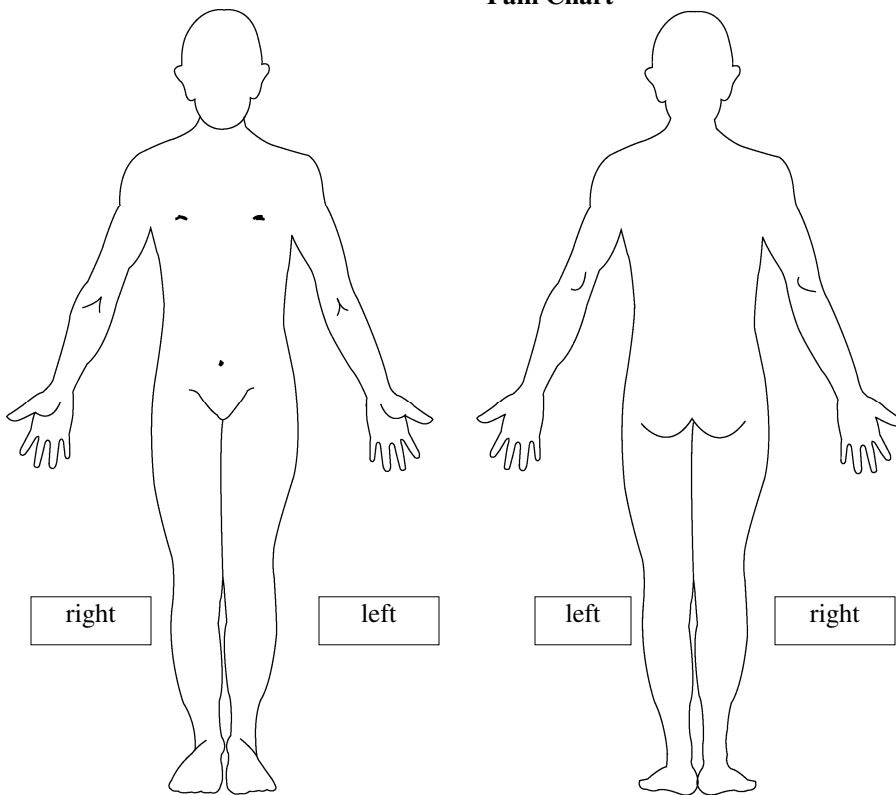


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Mark the areas on this body where you have concerns.
Include all concerned areas.

Please mark on the pain scale from **0 to 10** the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

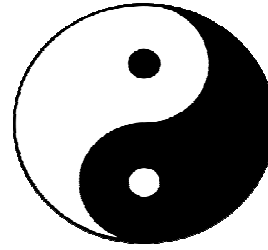
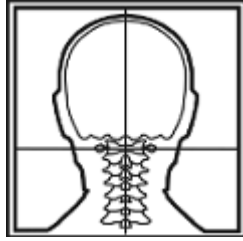
Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

List any other areas of pain or concern that you have since the accident:

- 1 _____
- 2 _____
- 3 _____
- 4 _____



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INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in contesting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care are:

Stroke: Stroke is the most serious complication of Chiropractic treatment. It is rare. According to the journal of CCA, vol. 37, no. 2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which is temporary or permanent brain dysfunction. On extremely rare conditions, death occurs.

Soreness: Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but please advise your doctor of Chiropractic of the soreness.

Soft Tissue Injury: Occasionally, Chiropractic treatment may aggravate a disc injury, or cause minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment X-rays are taken in cases considered at risk. Treatment is performed carefully to minimize such risk.

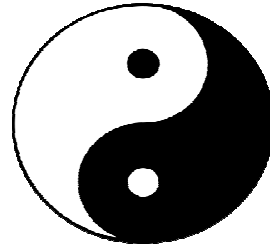
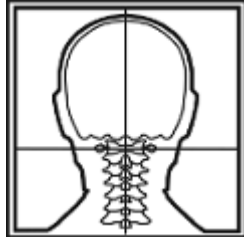
Physical Therapy Burns: Heat generated by physical therapy modalities can cause minor burns to the skin. These are rare, but should be reported, as well as other side effects you may be experiencing.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, condition, or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will refer you to another health care provider. If you have any questions, please ask your Doctor.

Having carefully read the above, I hereby give my informed consent to have Chiropractic treatment administered.

Printed name/ Date

Signature



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PROVIDER'S LIEN

To: _____

Re: Health Reports and Provider's Lien

I do hereby authorize my provider, **James Matthew Storey, D.C.** to furnish you with a full report of this examination, diagnosis, treatment, prognosis, etc. of myself in regard to the injury in which I was involved.

I hereby authorize and direct you to pay directly to said provider such sums as may be due and owing then for medical services rendered me, both by reason of this injury and by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I authorize **James Matthew Storey, D.C.** to sign my name to any check written in both our names, where such check is in payment for its services regarding my injury.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by them for services rendered me and that this agreement is made solely for said provider's additional protection and in consideration for their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment for verdict by which I may eventually recover said fee.

I forbid you from paying my provider any sums less than the full amounts owed to said provider without written consent:

Date: _____ Patient's Printed Name: _____
Patient's Signature: _____

The understanding being attorney or insurance company of record for this above patient hereby agree to observe all the terms or the above and agrees to withholds such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider above named.

Date: _____ Attorney/Insurance Representative Signature: _____

Please date, sign, and return on copy to Provider's Office
Keep a copy for your records
A photocopy of the form shall be considered as valid as the original