PARAMOUNT
CHIROPRACTIC
-Family Wellness-

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F Date: _____

Home Address: _____ Cell Phone: ( ) _____

City, State, Zip: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Females only: Pregnant: Yes / No Estimated due date: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

INSURANCE INFORMATION

Patient's Car Ins. Company: _____ Ins. Phone #: _____

Claim #: _____ Name of policy holder:_____

Adjuster's name:_____ Adjuster's phone number:_____

PIP insurance available: ☐ Yes ☐ No

Insurance company of other vehicle involved: _____ Ins. Phone #: _____

Claim #: _____ Name of policy holder:_____

Adjuster's name:_____ Adjuster's phone number:_____

Policy: _____

ACCIDENT INFORMATION

Date of accident: _____ Time of accident: _____

Driver of car: _____ Where were you seated:_____

Who owns the car:_____

Year and model of your car:_____

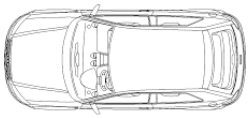
Year and model of other car:_____

What was the approximate amount of damage done to your car:_____

Was your vehicle towed from the scene: ☐ Yes ☐ No

Visibility at the time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other _____

Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dry ☐ other: _____

Where was the car struck: FRONT  REAR

In your own words, please describe the accident: _____

_____

_____

Illustrate how the accident happened:

Type of collision: ☐ Head-on ☐ Broad-side ☐ Front impact ☐ Rear end of car in front ☐ Rear impact ☐ Non-collision

At the time of the accident, what part of your head or body parts hit the inside of the car? _____

Did you see the accident coming: ☐ Yes ☐ No Did you brace for impact: ☐ Yes ☐ No

Did you have your seatbelt on: ☐ Yes ☐ No Did your seatbelt have a shoulder harness that was on: ☐ Yes ☐ No

What position was the headrest in compared to your head: ☐ Top of headrest even with bottom of head

☐ Top of headrest even with top of head ☐ Top of headrest even with middle of head

Was your car braking: ☐ Yes ☐ No Was your car moving at the time of impact: ☐ Yes ☐ No

If yes, estimate of how fast you were going _____mph The speed of the other car _____ mph

Head/body position at time of accident: ☐ Head turned left or right ☐ Head looking back ☐ Head straight forward

☐ Body straight in sitting position ☐ Body rotated left or right ☐ Other:_____

As a result of the accident were you: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _____

How was the shoulder harness adjusted: ☐ Loose ☐ Snug

Could you move all parts of your body ☐ Yes ☐ No

If no, what parts could you not move and why: _____

Were you able to get out of the car and walk unaided: ☐ Yes ☐ No If not, why not:_____

Did you get any bleeding cuts: ☐ Yes ☐ No If yes, where:_____

Did you get any bruises: ☐ Yes ☐ No If yes, where:_____

Describe how you felt immediately after the accident:_____

Later that day:_____

The next day:_____

Check the symptoms apparent since the accident:

☐ Headache ☐ Chest pain ☐ Neck pain/stiffness ☐ Mid-back pain ☐ Light sensitivity

☐ Light sensitivity ☐ Pain behind ears ☐ Dizziness ☐ Low-back pain ☐ Sleeping problems

☐ Diarrhea ☐ Loss of smell ☐ Numbness in toes ☐ Fainting ☐Cold feet

☐ Facial pain ☐ Loss of memory ☐ Fatigue ☐ Breath shortness ☐ Lost of taste

☐ Irritability ☐ Depression ☐Ringing/buzzing ☐ Cold sweats ☐ Loss of balance

☐ Tension☐ Constipation ☐ Cold hands ☐ Clicking/popping of jaw ☐ Numbness in fingers

☐ Other:_____

Have you missed time from work: ☐ Yes ☐ No

If yes, full time off of work _____ to _____

If yes, part time off of work _____ to _____

Did you seek medical care immediately after accident: ☐ Yes ☐ No

If yes, how did you get there: ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:_____

Doctor #1:_____ First visit date:_____

Were you examined: ☐ Yes ☐ No X-rays taken: ☐ Yes☐ No

Did you receive treatment: ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive: _____

What benefits did you receive from treatment: _____

Date of last treatment:_____

Doctor #2:_____ First visit date:_____

Were you examined: ☐ Yes ☐ No X-rays taken: ☐ Yes☐ No

Did you receive treatment: ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive: _____

What benefits did you receive from treatment: _____

Date of last treatment: _____

Do you have an attorney for this claim: ☐ Yes ☐ No

If yes, name of attorney: _____ Name of firm:_____

Address: _____City/St_____ Zip_____

Phone: _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

Do you take any supplements (i.e. vitamins, minerals?) _____

_____

Do you smoke or use tobacco products (including vaping)? ☐ Yes ☐ No ☐ Occasionally

Do you drink alcohol? ☐ Yes ☐ No ☐ Occasionally

HEALTH CONDITIONS

(before accident or exacerbated by accident)

☐ Anxiety/Depression	☐ Fatigue/Sleep Issues	☐ Digestive Troubles	☐ Dizziness	☐ Nausea/Vomiting
☐ Ringing in Ears	☐ Diabetes	☐ Sensitivity to Light	☐ Hypertension	☐ Loss of Concentration
☐ Arthritis	☐ Memory Problems	☐ Loss of Balance	☐ Headaches	☐ Neck/Back Pain
☐ Stiffness/Flexibility	☐ Pain in Arms/Legs	☐ Sinus Troubles/Allergies	☐ Irritability	☐ Cold Hands/Feet

☐ Other _____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

_____

Please list all past surgeries: _____

_____

Please list all previous accidents and falls: _____

_____

Is there anything else regarding your current condition you feel the doctor should know? _____

_____

_____

Please list all relevant family health history (diabetes, heart disease, cancer, autoimmune, etc) _____

_____

_____

CONSENT TO CARE

I do hereby authorize the doctors of Paramount Chiropractic to administer such care that is necessary for my particular case. This care may include consultation(s), examination(s), spinal adjustments and other rehabilitation and chiropractic procedures, including Insight scanning and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow Greg Prybylski D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____ *(If under age 18: Parent's signature)*

Pregnancy Release (If Applicable)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

Signature Date

Acknowledgement of Receipt
of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1) The right to review the notice prior to signing this consent,
2) The right to object to the use of my health information for directory purposes, and
3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: _____ Date: _____

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information to:

Name: _____ Relationship:_____

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

_____

_____

_____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