NEW LIFE CHIROPRACTIC

# ACCIDENT FORM

Date: _____/_____/_____

Name: _____ Date of Birth: ____/ ____/ _____ Age: _____ M / F

Mailing: _____ City: _____ State: _____ Zip: _____

Cell: _____ Carrier (ie: AT&T): _____ Email: _____

Social Security # _____ - _____ - _____ Occupation: _____

INSURANCE CO. _____ Claim #_____

INSURANCE PHONE #_____ FAX _____ EMAIL _____

INSURANCE MAILNG:_____ CITY _____ STATE _____ ZIP _____

ATTORNEY NAME:_____ PHONE _____ EMAIL/FAX_____

ATTORNEY ADDRESS: _____ CITY _____ STATE _____ ZIP _____

Who may we thank for referring you? _____

**ACCIDENT DATE**: _____/_____/_____ TIME _____ LOCATION: _____

IF WORK ACCIDENT, describe what happened, then skip down to TREATMENT:_____

IF CAR ACCIDENT: **circle any that apply:** driver/ passenger/ struck from front, behind, side Rt / Lt MPH:_____/ seat belt Y N

AMBULANCE **Y** **N** KNOCKED UNCONSCOUS **Y** **N** VEHICLE MAKE/MODEL _____

$ DAMAGE TO YOUR VEHICLE &/or OTHER DETAILS: _____

**TREATMENT FOLLOWING ACCIDENT**: _____

Circle anything you've experienced DURING, IMMEDIATELY AFTER & DAYS/WEEKS/MONTHS FOLLOWING ACCIDENT:

Headaches TMJ Rt / Lt Shoulder Rt / Lt Arm / Hand Rt / Lt Leg / Foot Rt/ Lt Hips Rt / Lt

Dizziness Neck Issues Sciatica Mid Back Pain Low Back Pain Fatigue Anxiety

**MAIN COMPLAINTS:** **RATE:** 1=mild, 10=unbearable **AFTER ACCIDENT -** activity restrictions, frequency of symptoms**ETC**

**1.**_____ _____ _____

**2.**_____ _____ _____

**3.**_____ _____ _____

**4.**_____ _____ _____

Fracture(s) location/year:_____ Spinal or other Surgery location/year: _____

Circle if you have ever had: Stroke Seizure Heart Issues Diabetes Cancer

Current Medications: _____

What health goals would you like to accomplish though Chiropractic Care? _____

# Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, offers considerable benefits. However, it may also provide some level of risk. Risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications which have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of disc and/or arthritic conditions, and, rarely, fractures. One of the rarest complications of chiropractic treatment is reported to be associated with adjustment to the neck (cervical spine) and that is an injury to an artery leading to stroke, said to occur at a rate between one claimed injury per one million adjustments to one to two million adjustments.

Prior to receiving chiropractic care in this office, a health history and physical examination must be completed. These procedures are performed to assess your specific conditions, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning your care.

## THE NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors in order to correct spinal and extremity joint subluxations. One of the most common disturbances to the nerve system is the vertebral subluxation. This condition is where one or more vertebrae in the spine are misaligned sufficiently enough to cause interference and/or irritation to the nerve system. The primary goal in chiropractic health care is to remove nerve interference caused by subluxation. A chiropractic adjustment is the application of a precise, high velocity movement of the spine over a very short distance. There are a number of different methods or techniques by which a chiropractic adjustment is delivered. Adjustments at New Life Chiropractic are typically delivered via a gentle instrument called an integrator/arthrostim or in some cases, by hand.

## CONSENT FOR CHIROPRACTIC CARE

Signing below indicates I understand and accept the risks associated with chiropractic care and give consent to the examination the doctor deems necessary, which may include instrumentation with a surface EMG along with the recommended chiropractic care, including spinal adjustments, as reported following my assessment.

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature | Date | Witness Signature |