Advanced Relief Chiropractic

PATIENT INTAKE FORM **Today's Date: _____**

Name _____ Birth date: _____

Address_____ City_____ State_____ Zip Code_____

Home Phone # _____ Cell Phone # _____ Social Security #_____

Emergency Contact_____ Phone: _____

Email: _____ Date of Collision _____

Briefly describe the collision below:

_____

_____

_____

( ) STRUCK WHILE STOPPED ( ) STRUCK ON LEFT SIDE ( ) STRUCK FROM BEHIND
( ) STRUCK WHILE MOVING ( ) STRUCK ON RIGHT SIDE ( ) STRUCK ON FRONT END

Please circle: Driver / Passenger Was there anyone else in the car with you? N / Y _____

Were both hands on the steering wheel? N / Y Which side was your head turned at impact? L / R / Straight

Where was your right foot at impact? Pedal / Floorboard / Ground

Where was your left foot at impact? Pedal / Floorboard / Ground

Your speed at time of collision: Stopped Slow Medium Fast

Other person's speed at time of collision: Stopped Slow Medium Fast

Seat belt on? N / Y Did the airbag go off? N/Y Was car drivable? N / Y Totaled? N / Y

Did you hit any objects in the car? N / Y _____ What part of your body did you hit? _____

Were you: Rendered Unconscious? N / Y Bleeding/Cut? N / Y Bruised? N / Y Where? _____

When did you begin having pain? Right Away Next day Other _____ Were you seen by Paramedics at the scene? N / Y

Did you go to the hospital? N / Y When? _____ Where? _____

How were you taken to the hospital? ( ) BY AMBULANCE ( ) DROVE YOURSELF ( ) BY RELATIVE OR FRIEND

What was done in the hospital? ( ) EXAMINATION ( ) X-RAYS ( ) CT SCAN OTHER _____

Were you given any prescriptions? N / Y What type? _____

OTHER DOCTORS / TREATMENT

Have you seen any other doctors for this collision other than today? N / Y Dr. Name _____

( ) FAMILY PHYSICIAN ( ) CHIROPRACTOR ( ) ORTHOPEDIST ( ) NEUROLOGIST ( ) OTHER_____

Advanced Relief Chiropractic
2418 W Indian Trail Ste A Aurora, IL 60506
Ph: (630) 907-1300 Fax: (630) 907-1644

WORK HISTORY

Are you currently employed? N / Y Job title/description _____

Have you lost any time from work because of this collision? N / Y If yes, how many days have you missed? _____

PAST AND CURRENT MEDICAL, FAMILY AND SURGICAL HISTORY

Have you been involved in any other collisions? N / Y When? _____ Any permanent injuries? N / Y _____

Are you currently taking any medication? N / Y If yes, what medications_____

For What:_____

DO YOU HAVE ANY ALLERGIES TO MEDICATION? N / Y If yes, to what?_____

Have you had any surgeries? N / Y If yes, type and year _____

Do you suffer from any other condition(s), or are you under the care of another physician for any condition(s)? N / Y

If yes, please explain_____

Anyone in your immediate family suffer from: CANCER DIABETES HEART DISEASE HIGH BP OTHER:_____

Relation: _____

PRESENT COMPLAINTS

Have you had any of the following complaints since the collision?
Please rate pain (1 – very mild, 10 – worst possible pain)

( ) Headaches ___/10
( ) Dizziness ___/10
( ) Nausea ___/10
( ) Blurred Vision ___/10
( ) Neck Pain ___/10
( ) Upper Back Pain ___/10
( ) Mid Back Pain ___/10
( ) Low Back Pain ___/10

( ) Shoulder Pain Right / Left ___/10
( ) Knee Pain Right / Left ___/10
( ) Ankle Pain Right / Left ___/10
( ) Foot Pain Right / Left ___/10
( ) Hip Pain Right / Left ___/10
( ) Wrist Pain Right / Left ___/10

( ) Pain radiating to: Arm / Hand / Fingers Right / Left ___/10
( ) Pain radiating to: Leg / Foot / Toes Right / Left ___/10
( ) Tingling or Numbness in: Arm/ Hand / Fingers Right / Left ___/10
( )Tingling or Numbness In: Leg/ Foot/ Toes Right / Left ___/10

How often are you experiencing pain: ( ) Constant ( ) Frequent ( ) Seldom

( ) Other Pain or Complaints _____

( ) Trouble sleeping: Avg __ hours sleep before collision / Avg __ hours sleep after collision

( ) Trouble performing household activities _____

( ) Difficulty STANDING or SITTING for long periods: Pain after _____ minutes / hours

( ) Pain when LIFTING or BENDING

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NOTICE OF DOCTOR'S LIEN

Patient:_____

Date of accident:_____

I herby authorize and direct my attorney or respective insurance provider to pay directly **Healthy Futures Chiropractic, Ltd. dba Advanced Relief Chiropractic** such sums that may be due and owed for medical services rendered to me by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate **Healthy Futures Chiropractic, Ltd. dba Advanced Relief Chiropractic**. I herby further give a lien on my first and/or third part case to **Healthy Futures Chiropractic, Ltd. dba Advanced Relief Chiropractic** against any and all proceeds of my settlement, judgment or verdict, which, may be paid to my attorney, or myself, as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible for all medical bills submitted by **Healthy Futures Chiropractic, Ltd. dba Advanced Relief Chiropractic** for services rendered to me and that this agreement is made solely for additional protection and in consideration of awaiting payment.

I agree to promptly notify **Healthy Futures Chiropractic, Ltd. dba Advanced Relief Chiropractic** of any changes or addition of attorney (s) used by me in connection with this accident and I instruct my attorney to do the same and promptly deliver a copy of this lien to any substituted or added attorney.

Signature_____ Date _____

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INFORMED CONSENT FORM

I herby request and consent to the performance of chiropractic treatments and other chiropractic / medical procedures, including various forms of physio and physical therapy and x-rays by **Advanced Relief Chiropractic .** This consent is extended to other licensed chiropractors, chiropractic assistants and/or licensed massage therapists, who are now or in the future employed by working with or associated with this office.

I certify that I have had the opportunity to discuss with the doctor of chiropractic and/or other office personnel the nature and purpose of the care that is being provided. I understand that results are not guaranteed. Further, I have been informed and understand that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me is not expected to be able to anticipate and explain all the possible risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care based on the facts known at the time and what is in my best interest.

I give my consent to **Advanced Relief Chiropractic** staff to take and use photos for the purposes of treatment, education, professional journals, and/or advertisement.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and treatment options have been explained. By signing this consent form I agree to the care being provided to me for the entire course of treatment for my present condition(s) or for any future condition(s) for which I seek treatment.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Patient's guardian or parent	Signature	Date

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CHIROPRACTIC APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your chiropractic care to Advanced Relief Chiropractic. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a $25 fee.

- This $25 fee will need to be paid in full before you will be able to schedule another appointment with Advanced Relief Chiropractic

- The fee is charged to the patient directly, not the insurance company

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact us and we may be able to waive this fee. You may contact us by email or by calling us and leaving a message if we are unable to answer. We do check our messages 7 days a week.

Advanced Relief Chiropractic (630)907-1300
drdanielpurdue@gmail.com

I have read and understand the Chiropractic Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

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