



NAME \_\_\_\_\_ DATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

**PLEASE PRINT**

What is your major complaint? \_\_\_\_\_

Other complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your:  Work  Sleep  Daily routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

List previous diagnosis and treatments you have received for present condition \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  "Pep" pills  Tranquilizers

Birth control  Other \_\_\_\_\_

Dental visits:  6 months  Yearly  Toothache only  Complete dentures

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

Have you ever been in an auto accident?  Past year  Past 5 years  Over 5 years  Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders?  Yes  No When \_\_\_\_\_

Have others in your family had such disorders?  Yes  No When \_\_\_\_\_

**FAMILY HEALTH INFORMATION** (Many health problems are the result of heredity spinal weaknesses; thus information about your family members will give us a better picture of your total health picture).

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER: YES NO

Been knocked unconscious?

Used a cane, crutch or other support?

Been treated for a spine or nerve disorder?

Had a fractured bone?

Been hospitalized for other than surgery?

DO YOU: YES NO

Now take vitamins or minerals?

Think you may need vitamins or minerals?

Have an allergy to any drug?

DATE OF LAST: Less than 6 months 6 - 18 months Over 18 months Never

Spinal examination

Physical examination

Blood test

Chest X-Ray

Spinal X-Ray

Dental X-Ray

Urine test

HABITS Heavy Moderate Light None

Alcohol

Coffee

Tobacco

Drugs

Exercise

Sleep

Appetite

List below all conditions for which you have been treated in the past 10 years.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home?):

NAME: \_\_\_\_\_ Phone \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

**Automotive Crash Form**

**Billing Information**

Patient Name: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_  AM  PM

City and Street where crash occurred: \_\_\_\_\_

What is the estimated damage to your vehicle? \$ \_\_\_\_\_

**Yes No**

Do you have automobile medical insurance coverage? \_\_\_\_\_

\_\_\_\_\_  
Name/address/phone \_\_\_\_\_

\_\_\_\_\_  
What is your car insurance medical coverage limit? \$ \_\_\_\_\_

\_\_\_\_\_  
What is the claim number? \_\_\_\_\_

Do you know the claims adjuster's name? \_\_\_\_\_

Have you reported this injury to your car insurance company? \_\_\_\_\_

Did the police come to the accident scene and make a report? \_\_\_\_\_

Is an attorney representing you? Name/address/phone: \_\_\_\_\_

\_\_\_\_\_

**Auto Accident Description**

**Describe how the crash happened** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Collision Description**

Check all that apply to you:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Single-car crash | <input type="checkbox"/> Two-vehicle crash  | <input type="checkbox"/> More than three vehicles |
| <input type="checkbox"/> Rear-end crash   | <input type="checkbox"/> Side crash         | <input type="checkbox"/> Rollover                 |
| <input type="checkbox"/> Head-on crash    | <input type="checkbox"/> Hit guardrail/tree | <input type="checkbox"/> Ran off road             |

**You were the:**

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="checkbox"/> Driver | <input type="checkbox"/> Front Passenger | <input type="checkbox"/> Rear Passenger |
|---------------------------------|--|---|

**Describe the vehicle you were in**

Model year and make: \_\_\_\_\_

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Subcompact car | <input type="checkbox"/> Compact car  | <input type="checkbox"/> Mid-size car              |
| <input type="checkbox"/> Full-size car  | <input type="checkbox"/> Pickup truck | <input type="checkbox"/> Larger than 1 ton vehicle |

**Describe the other vehicle**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Subcompact car | <input type="checkbox"/> Compact car  | <input type="checkbox"/> Mid-size car              |
| <input type="checkbox"/> Full-size car  | <input type="checkbox"/> Pickup truck | <input type="checkbox"/> Larger than 1 ton vehicle |

**Estimated crash speeds**

Estimate how fast your vehicle was moving at time of crash. \_\_\_\_\_ mph

Estimate how fast the other vehicle was moving at time of crash. \_\_\_\_\_ mph

Patient \_\_\_\_\_ Date \_\_\_\_\_

**At the time of impact your vehicle was**

- Slowing down
- Stopped
- Gaining speed
- Moving at a steady speed

**At the time of impact the other vehicle was**

- Slowing down
- Stopped
- Gaining speed
- Moving at a steady speed

**During and after the crash, your vehicle**

- Kept going straight, not hitting anything
- Kept going straight, hitting car in front
- Was hit by another vehicle
- Spun around, not hitting anything
- Spun around, hitting car in front
- Spun around, hitting object other than car

**Describe yourself during the crash**

Check only the areas that apply to you:

- You were unaware of the impending collision.
- You were aware of the impending crash and braced yourself.
- Your body, torso, and head were facing straight ahead.
- You had your head and/or torso turned at the time of collision:
  - Turned to left
  - Turned to right
- You were intoxicated (alcohol) at the time of the crash.
- You were wearing a seat belt.
  - If yes, does your seat belt have a shoulder harness?  Yes  No
- You were holding onto the steering wheel at the time of impact.

**Indicate if your body hit something or was hit by any of the following:**

Please draw lines and match the left side to the right side.

- |          |                  |
|----------|------------------|
| Head     | Windshield       |
| Face     | Steering wheel   |
| Shoulder | Side door        |
| Neck     | Dashboard        |
| Chest    | Car frame        |
| Hip      | Another occupant |
| Knee     | Seat             |
| Foot     | Seat belt        |

**Check if any of the following parts broke, bent, or were damaged in your car**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Windshield     | <input type="checkbox"/> Seat frame       | <input type="checkbox"/> Knee bolster |
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Side/rear window | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Dashboard      | <input type="checkbox"/> Mirror           | <input type="checkbox"/> Other _____  |

**Rear-end collisions only**

Answer this section only if you were hit from the rear.

- Does your vehicle have:
- Movable head restraints
  - Fixed, non-movable head restraints
  - No head restraints

Please indicate how your head restraint was positioned at the time of the crash.\*

- At the top of the back of your head
- Midway height of the back of your head
- Lower height of the back of your head
- Located at the level of your neck
- Located at the level of your shoulder blades (upper back) below neck

\*Estimate the distance between the back of your head and the front of the head restraints. \_\_\_\_\_ inches

**All types of collisions**

Answer this section regardless of the type of crash, indicating those relevant to your care.

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of the front or side structures, such as the side door, dashboard, or floor board of your car, dent inward during the crash? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the side door touch your body during the crash?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Were your hands on the steering wheel or dashboard during the crash?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your body slide under the seat belt?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Was a door of your vehicle damaged to the point where you could not open it?   |

**Emergency department**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you go to the emergency department after the accident?             |
| <input type="checkbox"/> | <input type="checkbox"/> | What is the name of the emergency department? _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | When did you go (date and time)? _____                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you go to the emergency department by ambulance?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you or another person drive you to the emergency department?       |
| <input type="checkbox"/> | <input type="checkbox"/> | Where you hospitalized overnight?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the emergency department doctor take x-rays? Check what was taken: |
|                          |                          | <input type="checkbox"/> Skull   |
|                          |                          | <input type="checkbox"/> Neck  |
|                          |                          | <input type="checkbox"/> Low back                                      |
|                          |                          | <input type="checkbox"/> Arm or leg                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the emergency department doctor give you pain medications?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the emergency department doctor give you muscle relaxants?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have any cuts or lacerations?                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you require any stitching for cuts?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you given a neck collar or back brace to wear?                    |

**When did you first notice any pain after injury?**

- Immediately                                       \_\_\_\_\_ Hours after injury                                       \_\_\_\_\_ Days after injury

**If you did not see a doctor for the first time within the first week, indicate why**

Check all that apply

- |  |  |
|--|--|
| <input type="checkbox"/> No pain was noticed | <input type="checkbox"/> No appointment schedule available |
| <input type="checkbox"/> No transportation   | <input type="checkbox"/> Work / home schedule conflicts    |

**If you did not see a doctor for the first time within the first month after injury, indicate why**

Check all that apply

- |   |   |
|---|---|
| <input type="checkbox"/> No pain was noticed                        | <input type="checkbox"/> No appointment schedule available  |
| <input type="checkbox"/> No transportation                          | <input type="checkbox"/> Work / home schedule conflicts     |
| <input type="checkbox"/> I thought pain would go away               | <input type="checkbox"/> I had no insurance or money        |
| <input type="checkbox"/> I self treated with over-the-counter drugs | <input type="checkbox"/> I took hot showers, used ice, heat |

**Have you been unable to work since injury?**

- Yes     No      If yes, you were off work     partially or     completely

Please list date off work: \_\_\_\_\_ to \_\_\_\_\_.

# New Smyrna Spine & Injury Center Informed Consent

Patient Name: \_\_\_\_\_ File #: \_\_\_\_\_ Date: \_\_\_\_\_

Chiropractic Healthcare is an art and a science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities called subluxation<sup>7</sup>. Subluxation exists when one or more vertebrae in the spine or bones in the extremity are misaligned sufficiently enough to result in damage or irritation to either the nearby nerves, joints and/or tissues. The primary goal of chiropractic treatment is the removal of subluxation(s). This is accomplished by performing a procedure unique to the chiropractic profession called an “adjustment”. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are performed by hand and also by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (e.g. heat, ice, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some “reaction” to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care<sup>(1)</sup>.

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

### Rare, Yet Possible Side-Effect Complications

- Rib Fracture
- Burns (if certain types of physiotherapy are used)
- Disc herniation
- Cauda Equina Syndrome <sup>(2)</sup> (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1,000,000 cervical spine adjustments)<sup>(3)</sup>

In addition to national guidelines <sup>(4)</sup>, we have set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect absolute or relative contraindications to the standard chiropractic treatment.

1. Senstad O, et al. Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997;22:435-41
2. Shekelle PG, et al. Spinal manipulation for low back pain. Ann Intern Med 1992;117(7):590-8
3. Haldeman S, et al. Risk factors and precipitating neck movements causing vertebrobasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999;(24):785-94
4. Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameters. Aspen Publishers, 1997

PLEASE SIGN THIS FORM AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR AND BEFORE ANY CARE OR TREATMENT IS RENDERED.

I have read the previous information regarding risks of chiropractic care and my clinician has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT'S SIGNATURE <b>X</b>	_____	Date	_____
PARENT/GUARDIAN'S SIGNATURE <b>X</b>	_____	Date	_____
DOCTOR'S SIGNATURE <b>X</b>	_____	Date	_____



## Treatment Scheduling Agreement

By accepting Dr. Walsh as your chiropractic and acupuncture health care provider, you are participating in a tradition of exceptional chiropractic and acupuncture care established years ago. As part of our family of patients, it is vital that we have an open line of communication. Your access to us and our access to you is the foundation of a long lasting relationship.

Trying to accommodate every patient's individual needs and work schedules can be a difficult task but we always do our best. We work very hard to stay on schedule so that you will not spend unnecessary time waiting for your appointment. To us, a scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When you miss an appointment the result is a permanent loss of that time which could have been used to treat other patients in need.

We ask that when you schedule an appointment you make every effort to keep that commitment. Since various circumstances or personal emergencies may keep you from your commitment with us, we always take that into consideration when receiving a last minute schedule change. If however, you must cancel on short notice you will be asked to pay for your chiropractic or acupuncture care prior to making your next appointment. If you cancel the prepaid appointment on short notice you will forfeit a minimum charge of 50% of the procedure fee. If you arrive more than 10 minutes late for your appointment it may be necessary to reschedule your appointment. The same forfeiture penalties apply if we must reschedule due to tardiness.

When you find that you cannot keep your scheduled appointment, we ask that you provide a minimum notice of one full business day. Your cooperation will allow us to schedule other patients in need of our care. For your convenience we have a scheduling coordinator available to you Monday through Friday.

### Financial Philosophy

We are committed to providing you with the highest quality of chiropractic and acupuncture care utilizing only the best equipment, materials and education available. In order to continue to provide excellent service and care to you, we have formulated this financial policy.

Our office accepts cash, personal checks, Mastercard, Visa and Discover. Outside financing is available upon request and approved credit.

For those of you with insurance, as a courtesy, we will assist you in processing your insurance claims. In order for our office to file your insurance claim, you must bring proof of insurance at your first appointment and then once a year thereafter. You will be responsible for the entire cost of your first visit and thereafter for your uninsured portion at the time treatment is rendered.

All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your chiropractic and acupuncture provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and/or the insurance company. Our office is not a party to that contract or any possible restrictions.

Returned checks are subject to a service charge. Additionally, charges may be incurred for broken appointments and appointments cancelled or rescheduled without one full business day advance notice.

I, the patient, agree to pay any and all collection costs and attorney's fees associated with collection of any account that becomes delinquent.

If you have any questions regarding our financial policy or our appointment scheduling policy, please do not hesitate to ask. We are committed to providing you with the highest level of service and excellence in chiropractic and acupuncture care.

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Signature of patient/responsible party

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Date

