Hometown Chiropractic **Dr. Ryan Walton**

Patient Name: _____ Date: _____

PATIENT PERSONAL / CONFIDENTAL DATA

Address:_____City:_____ State: _____ Zip Code :_____

H. Phone: _____W. Phone:_____ Cell Phone: _____

Date of Birth:_____ Age:_____ Sex: M F Marital Status: M S D W

Email Address: _____ Social Security #_____

Name of Spouse: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Place of Employment: _____

How did you hear about our clinic? _____

Have you ever received Chiropractic Care? Yes / No If yes, when and name of Dr:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **[Ryan Walton/ Hometown Chiropractic]** for services performed.

Patient or Guardian Signature _____ Date_____

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt of the Notice of Privacy Practices of Hometown Chiropractic Herein after referred to as *the Clinic*.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by *the Clinic* to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name Date

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

Please list below the names and your relationship of people to whom you authorize *the Clinic* to release your private health information:

Print Name Relationship

_____

_____

_____

_____

Hometown Chiropractic **Dr. Ryan Walton**

Patient Name: _____ Date: _____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____
_____
_____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   - A. Loss of Range of Motion: yes/no
     - a. What body parts: _____
   - B. Visual Disturbance : yes/no (please explain): _____
   - C. Dizziness: yes/no How often: _____
   - D. Anxiety: yes/no How often: _____
   - E. Depression: yes/no How often: _____
   - F. Difficulty Sleeping: yes/no How often: _____

3. **Past Health History:**

   A. Previous illnesses you've had in your life:

   _____

   B. Previous Injury or Trauma:

   _____

   Have you ever broken any bones? Which?

   _____

   C. Allergies:

   _____

   D. Medications:

   Medication Reason for taking

   _____
   _____
   _____
   _____

   E. Surgeries:

   Date Type of Surgery

   _____
   _____
   _____
   _____

4. **Family Health History:**

Associated health problems of relatives:

_____
_____
_____

Patient Name: _____ Date: _____

5. Social and Occupational History:

A. Job description:

_____

B. Recreational activities:

_____

C. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

6. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

7. Are you interested in (check the box)?

- ☐ **Pain Relief**
- ☐ **Nutrition and Diet Information**
- ☐ **Supplement information and comparison**
- ☐ **Exercise information**
- ☐ **Stress Relief**
- ☐ **Wellness and Overall Health Improvement**
- ☐ **Receiving bimonthly newsletters via email**

Patient Name: _____ Date: _____

Symptom 1 (describe symptom & location)

_____

- On a scale from 0-10, with **10 being the worst**, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- HOW did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - WHEN did the symptom begin? _____
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity: 10 20 30 40 50 60 70 80 90 100
- How long does each episode last? _____
- Is the symptom worse at **certain times** of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Describe the **quality** of the symptom (circle all that apply):
  - Dull, Sharp, Sharp w/ movement, Throbbing, Burning, Deep, Aching Tingling, Stabbing, Cramping, Pinprick, Numbness, Radiating, Other (please describe): _____
- How are your symptoms **changing**? (circle one)
  - Getting better, same, getting worse
- Does the symptom **radiate** to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- What makes the symptom **worse**? (circle all that apply):
  - Sitting, Standing, Walking, Bending, Stooping, Lifting Sleeping, Sneezing, Coughing, Straining, Reaching, Twisting Looking up, Looking Down, Movement, Rest, Lying Supine, Driving, Typing, Scooping, Household Chores, Exercise, Stair Stepping, Other (please describe):_____
- What makes the symptom **better**? (circle all that apply):
  - Sitting, Standing, Lying Down, Knees bent up, Leaning against support, No movement occurs, Movement occurs, Heat is applied, Ice is applied Analgesic topical pain relief gel is applied, Ibuprofen is taken, Medication, Rest occurs, Stretching/Exercise is used, Adjustments are provided, Nothing relieves, other (please describe): _____
- Since the symptom started, how much has the pain **interfered with work**? (circle):
  - Not at all, a little bit, moderately, quite a bit, extremely, can't work
- Since the symptom started, how much has the pain interfered with your **social activities**? (circle)
  - None of the time, a little of the time, some of the time, most of the time, always
  - What social activities are **most affected** by your symptom? _____

Patient Name: _____ Date: _____

Symptom 2 (describe symptom & location)

_____

- On a scale from 0-10, with **10 being the worst**, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- HOW did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - WHEN did the symptom begin? _____
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity: 10 20 30 40 50 60 70 80 90 100
- How long does each episode last? _____
- Is the symptom worse at **certain times** of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Describe the **quality** of the symptom (circle all that apply):
  - Dull, Sharp, Sharp w/ movement, Throbbing, Burning, Deep, Aching Tingling, Stabbing, Cramping, Pinprick, Numbness, Radiating, Other (please describe): _____
- How are your symptoms **changing**? (circle one)
  - Getting better, same, getting worse
- Does the symptom **radiate** to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- What makes the symptom **worse**? (circle all that apply):
  - Sitting, Standing, Walking, Bending, Stooping, Lifting Sleeping, Sneezing, Coughing, Straining, Reaching, Twisting Looking up, Looking Down, Movement, Rest, Lying Supine, Driving, Typing, Scooping, Household Chores, Exercise, Stair Stepping, Other (please describe):_____
- What makes the symptom **better**? (circle all that apply):
  - Sitting, Standing, Lying Down, Knees bent up, Leaning against support, No movement occurs, Movement occurs, Heat is applied, Ice is applied Analgesic topical pain relief gel is applied, Ibuprofen is taken, Medication, Rest occurs, Stretching/Exercise is used, Adjustments are provided, Nothing relieves, other (please describe): _____
- Since the symptom started, how much has the pain **interfered with work**? (circle):
  - Not at all, a little bit, moderately, quite a bit, extremely, can't work
- Since the symptom started, how much has the pain interfered with your **social activities**? (circle)
  - None of the time, a little of the time, some of the time, most of the time, always
  - What social activities are **most affected** by your symptom? _____

Patient Name: _____ Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened:

_____

_____

_____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**:

_____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**:

_____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

3b) Were you leaning forward at the time of impact? **Yes** / **No**

4) What type and year of vehicle were you in?

_____

4a) What was the approximate speed of your vehicle when the accident occurred?
_____ mph

5) What type and year of vehicle struck yours?

_____

5b) What was the approximate speed of the other vehicle when the accident occurred?
_____ mph

6) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

7) Did you feel pain immediately after the accident? **Yes** / **No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Patient Name: _____ Date: _____

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**:

_____
_____
_____

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches /**
Muscle Relaxants / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** /
Instructed to Call a Private Physician / **Referred to This Office** / **Other** _____:

What other doctor have you seen as a result of this injury?
_____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above:

_____
_____
_____
_____
_____

_____ _____
Patient Signature Date

Hometown Chiropractic **Dr. Ryan Walton**

Patient Name: _____ Date: _____

Duties Under Duress Summary

Complete the following summary as it relates to your **living and work duties** and how **the injury(s) are affecting your performance**. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work	**Reason for the difficulty**	**Duration**
Job Description: _____		
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____
Studies/School	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____
Domestic Duties	**Reason for the difficulty**	**Duration**
Vacuuming	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____
Household Duties	**Reason for the difficulty**	**Duration**
Yard work	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____