BELANGER CHIROPRACTIC LIFE CENTER

Specializing in Atlas Orthogonal Chiropractic Sheila E. Belanger, D.C.
1003 East Freeway Dr SE Conyers, GA 30094
Phone 770-760-1394 Fax 770-760-8414

AUTOMOBILE ACCIDENT HISTORY FORM

(PLEASE PRINT)

Patient Name _____ Date of Birth _____ Today' Date: _____

Date of Accident _____ Time of Accident _____ AM / PM ☐Daylight ☐Dawn ☐Dusk ☐Dark

City of Accident _____ State of Accident _____ Street Address _____

Was accident on the job? ☐ Yes ☐ No

Road conditions at the time of the accident: □ **WET** □ **DRY** □ **ICY** □ **OTHER**: _____
Did the police come to the accident scene? □ **NO** □ **YES** Is there a report? □ **NO** □ **YES**
Did you go to the hospital? □ **NO** □ **YES,** If ***yes***, which hospital? _____

How did you get to the hospital? _____ What areas of you were X-rayed? _____

What did the hospital do for your injuries? (Collar, splints, medication, etc.) _____

How long did you stay at the hospital? _____ What was their diagnosis? _____

What did they recommended for follow-up care? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear-seat ☐ Other
Were you aware of the approaching collision prior to impact, or did it catch you by surprise? □ **AWARE** □ **SURPRISE**
Did you lose consciousness (black out) upon impact? □ **NO** □ **YES,** How long? _____
Did you experience a flash of light or explosion in your head? □ **NO** □ **YES**

At the time of the accident, did you become or experience any of the following?

□ Confused	□ Disoriented	□ Light headed	□ Dizzy	□ Nauseated
□ Blurred vision	□ Ringing / buzzing in ears		□ Loss of balance	□ Other

Do you still have any of those symptoms? If yes, which ones?

Check symptoms you have noticed since the accident.

□ Headache	□ Dizziness	□ Depression	□ Fatigue
□ Light bothers eyes	□ Buzzing in ears	□ Diarrhea	□ Neck pain
□ Loss of memory	□ Feet cold	□ Neck stiff	□ Pins and needles in arms
□ Hands cold	□ Fainting	□ Sleeping problems	□ Loss of balance
□ Face flushed	□ Pins and needles in legs	□ Constipation	□ Tension
□ Numbness in fingers	□ Loss of smell	□ Fever	□ Irritability
□ Loss of taste	□ Chest pain	□ Cold sweats	□ Shortness of breath
□ Reduced tolerance to alcohol	□ Stomach upset	□ Ears ring	□ Head seems too heavy
□ Nervousness	□ Numbness in toes	□ Back pain	□ Reduced tolerance to heat

Was any other doctor consulted after your accident? □ **NO** □ **YES**, If ***yes***, who? _____

What was the diagnosis? _____ What was the treatment? _____

How often did you see the doctor? _____ For how long? _____

Have you ever had any complaints in the involved area before? □ **NO** □ **YES**; If ***yes***, what complaints: _____

_____

Have you been involved in any previous accidents? If so, when? _____
Are your work activities restricted as a result of this accident? □ **NO** □ **YES**

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Since the injury are your symptoms: ☐ Improving? ☐ Getting worse? ☐ Same?

Head-rest / restraint: ☐ None ☐ Integrated type ☐ Adjustable type ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the accident? □ **NO** □ **YES**
Was the seat adjustment altered by the accident? □ **NO** □ **YES** Was the seat broken by the accident? □ **NO** □ **YES**
Did air-bag deploy? □ **NO** □ **YES,** If ***yes***, did it strike you? □ **NO** □ **YES**
Were you wearing a seatbelt? □ **NO** □ **YES** □ **Don't Know** If ***yes***, was it a: □ **lap belt** or a □ **shoulder-lap belt ?**
Did you receive any injury or bruise from the seat belt? □ **NO** □ **YES**

Check the following that were damaged during the accident: ☐ Steering wheel ☐ Windshield ☐ Seat ☐ Rear-view mirror

☐ Other:_____

Was your body facing straight forward at the time of the collision? □ **YES** □ **NO,** How was it turned? _____

Was your head pointed forward? □ **YES** □ **NO,** What direction was it turned and by how much? _____

Where were your hands? ☐ One on the wheel ☐ Two on the wheel ☐ Not applicable
Were you wearing a hat or glasses at the time of impact? □ **NO** □ **YES** Were they still on after the accident? □ **NO** □ **YES**

YOUR CAR:
List the year, make and model of the car you were in: YEAR:_____ MAKE:_____ MODEL:_____
Was your car stopped at the time of impact? □ **NO** □ **YES;** If ***yes***, was the driver's foot on the brake? □ **NO** □ **YES**

If ***no***, then estimate the speed of the vehicle you were in: _____ MPH
If your vehicle was moving at the time of impact, was it: □ Slowing down □ Gaining speed □ Steady speed
What is the estimated cost of damage to the vehicle you were in? **$**

THE OTHER CAR:
What is the year, make and model of the other vehicle? YEAR:_____ MAKE:_____ MODEL:_____

Was the other vehicle moving at the time of collision? □ **NO** □ **YES;** If ***yes***, what was the approximate speed? _____MPH
At the time of impact, was the other vehicle: □ Slowing down □ Gaining speed □ Steady speed
Estimate the damage to the other vehicle: □ None □ Minimal □ Moderate □ Major

You may draw the accident here

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in:_____ Name of their auto insurance:_____

Owner of the automobile you were in:_____ Name of their auto insurance:_____

Insurance company phone#:_____ Claim#: _____

Driver of the other automobile:_____ Name of their auto insurance:_____

Owner of the other automobile:_____ Name of their auto insurance:_____

Insurance company phone#:_____ Claim#: _____

Note: A lien may be filed on personal injury accounts.

Have you retained an attorney? □ NO □ YES, Name and Phone #: _____

Welcome to ***Belanger Chiropractic Life Center***

(PLEASE PRINT NEATLY) ***Your Medical Record at our office requires the following information.***

Patient Information

Legal First Name:	**MI:**	**Last Name:**	**Date of Birth:**

Female Male _____

Sex Social Security #

Marital Status, Circle: Single Married Widowed Divorced

Spouse Name:_____

Address: Street City State Zip

_____ _____ Home Phone: _____

Cell Phone, Txt Msg? Yes No **Email Address**

Work Phone: _____

Emergency Contact Info

Contact Name:_____ **Contact Phone:**_____

How did you hear about us? / Who were you referred by? _____

Purpose for contacting us? _____

Other doctors seen for this condition: □ YES □ NO If yes, doctors' names and prior treatments: _____

_____

Other health problems? _____

Patient Demographics

Due to recent changes in the healthcare industry, we are asked to gather the following information from our patients.

- Occupation:_____ Employer Name & City, State:_____
- Preferred Language(s): __English __Spanish __French __German __Russian __Indian __Japanese __Chinese __Korean
- Race: __American Indian or Alaska Native __Native Hawaiian or Pacific Islander __Black or African American __Hispanic or Latino __Asian __White or European American __Decline to Answer __Not Listed:_____
- Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Decline to Answer

Insurance Information

We will make a copy of your insurance card(s). However, please complete the following information.

Primary Policy Holder's Info

Insurance Company:	
Policy Holder's Name (First MI Last):	
Policy Holder's DOB:	Policy Holder's SS#:
Policy Holder's Employer:	

Is patient the Policy Holder? Yes No

If No, who is the Policy Holder: Spouse Parent Employer Other

Secondary Policy Holder's Info

Secondary Insurance Company:	
Policy Holder's Name (First MI Last):	
Policy Holder's DOB:	Policy Holder's SS#:
Policy Holder's Employer:	

Is patient the Policy Holder? Yes No

If No, who is the Policy Holder: Spouse Parent Employer Other

I authorize the release of any medical or other information necessary to process all claims performed by any of the above said physicians. I also request payment of government and/or private benefits to myself or to the party who accepts assignment on this and all future claims. We are filing your insurance as a courtesy to you. Therefore if your insurance fails to pay for any treatment on your behalf, you will be responsible for the balance due. By signing below, you agree to the above terms and conditions.

→ Signature of Patient:_____ Date:_____ / _____ / _____

(or responsible party if patient is under the age of 18 years)

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PATIENT HISTORY FORM

(PLEASE PRINT)

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name: _____ Date: _____

Health History

Have you tested positive for: HIV/AIDS? __No **__Yes or Hepatitis?** __No **__Yes: __A __B __C __D __E**

Do you smoke? __Never __Former Smoker __Current/Every Day Smoker __Current/Some Days Smoker

Have you…been diagnosed with Hypertension? __No **__Yes,** Name of Treating Physician:_____

…been diagnosed with Diabetes? __No **__Yes,** Circle: **Type I Type II,** Name of Treating Physician:_____

Do you have any allergies? __Food __Environmental __Medication

List type of allergy & reaction: _____

_____

Are you <u>currently</u> taking any medications (including OTC) / vitamins / supplements? __No **__Yes,** Please list below:

If you have brought a list with you, let the front desk make a copy, and write "SEE ATTACHED" below.

Name	Strength/Dosage	Frequency	Prescribing Physician
		__3x Daily __2 x Daily __1x Daily __As Needed __Other:	
		__3x Daily __2 x Daily __1x Daily __As Needed __Other:	
		__3x Daily __2 x Daily __1x Daily __As Needed __Other:	

Check any of the following ailments / conditions that pertain to you.

□ Abdominal cramps	□ Allergies:_____	□ Breathing difficulty	□ Ankle swelling	□ Arthritis
□ Bladder trouble	□ Blood clots	□ Colitis	□ Bursitis	□ Cancer:_____
□ Chest pain	□ Clicking jaw	□ Diarrhea	□ Constipation	□ Convulsions
□ Depression	□ Diabetes	□ Excessive thirst	□ Diverticulitis	□ Dizziness
□ Earaches	□ Eating disorder	□ Gallbladder problems	□ Fainting	□ Fatigue
□ Forgetfulness	□ Frequent nausea	□ Heart condition:_____	□ Gas / bloating	□ Headaches / Migraines
□ Hearing difficulty	□ Heartburn	□ Irregular heartbeat	□ Irritable bowel syndrome	□ Hemorrhoids
□ High blood pressure	□ High cholesterol	□ Pain between shoulders	□ Lupus	□ Jaw pain / TMJ
□ Liver problems	□ Lung problems / congestion	□ Spasms / cramps	□ Paralysis:_____	□ Lymphedema
□ Numbness / tingling in extremities		□ Tendonitis	□ Prostate problems	□ Sinus problems
□ PMS	□ Poor / Excessive appetite	□ Other:_____	□ Stress	□ Stroke
□ Sleep disorder:_____		□ Other:_____	□ Varicose veins	□ Vision problems
□ Swelling:_____				
□ Vomiting	□ Weight trouble			

Family History:_____

Previous Chiropractic Care: ☐ NO ☐ YES Chiropractor Name: _____

Date of Last Visit: _____/_____/_____ Reason: _____

Is there any posibility you might be pregnant? ☐ NO ☐ YES How many weeks?_____

Please enter the date of the first day of your last menstrual period. (Month & Day) _____

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List any previous accidents, injuries (ex: car accidents, sports injuries) or surgeries: _____

_____

List any major illnesses or broken bones: _____

Main Complaint(s)	How Intense? (0 - least; 10 - worst)	How Frequent?	Is it Getting Worse, Better, or Staying Same?
1. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS
2. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS
3. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS
4. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS

When did you first notice this/these problem(s)?_____

How does this condition intefere with normal living and working? _____

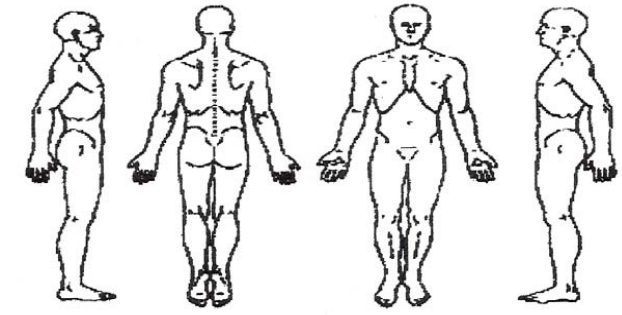
_____

Was your condition caused by: ☐ Auto ☐ On job injury Employer: _____ ☐ Other _____

Describe: _____

_____

Please use the diagram to mark the areas of your body which are causing you pain



NOTICE OF PRIVACY PRACTICES: EFFECTIVE April 14, 2003 As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPPA): This notice describes how health related information about you may be disclosed, and how you can get access to this information. We are required by law to maintain confidentiality of health information that identifies you as well as your health status. Your Protected Health Information (PHI) can be used for treatment, payment, and health care operations. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization except to the extent that your physician or the practice has taken action in reliance on the use or disclosure indicated in the authorization. Upon written request, you have the right to request that our practice communicate with you about your health and related issues in a particular manner. You may also request us, in writing, to amend your health insurance information if you believe it to be incorrect or incomplete. You have the right to request a restriction, in writing, in our use or disclosure of your PHI for treatment, payment, or health care operations and for non-treatment or operations purposes. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. We reserve the right to revoke any voluntary agreement to restrict the use or disclosure of your PHI that we may enter into.

→ Signature of Patient:_____ Date:____ / ____ / ____

(or responsible party if patient is under the age of 18 years)