DIMOND CHIROPRACTIC

Date: _____ PT NUM # _____

Name: _____

First MI Last

Physical Address_____ City, State, Zip:_____

Mailing Address_____ City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Sex ___M ___ F Birth date: _____ Age ____ Driver's License # & State:_____

SSN:_____ **Check one**: __ Married __ Single **# of children**:_____

Employer:_____ Occupation:_____

Spouse Name: _____Spouse Employer: _____

Emergency Contact:

Name_____Phone_____Relationship_____

Who can we thank for referring you to our office: _____

Reason for consulting this office: _____

Is this injury due to a work or auto accident?_____ Date of Injury: _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance Company:_____ Phone Number_____

Subscriber:_____ Date of Birth: _____ Relationship to Subscriber: _____

ID#_____ Group#_____

Secondary Insurance Company:_____ Phone Number_____

Subscriber:_____ Date of Birth: _____ Relationship to Subscriber: _____

ID#_____ Group#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents. I also authorize Dimond Chiropractic Center to release any information required to process my claims. I also hereby authorize Dr. Shawn Woodmansee and whomever he may designate as assistants to administer care as deemed necessary.

Patient/Guardians Signature_____

Privacy Practices

I have been offered the Notice of Privacy Practices and I have been provided an opportunity to review it if needed.

Patient Name _____

_____
Signature
Date of Birth _____
Date _____

FINANCIAL POLICY

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED: As a courtesy to our patients, we do allow other payment options within the guidelines of our office policy.

CASH: We accept cash, check, Debit, Visa, MasterCard, Discover and American Express. Payment for service is due at the time services are rendered, unless payment arrangements have been approved in advance. Returned checks are subject to a $15.00 service charge.

GROUP INSURANCE: Patients are responsible for payment in full at the time of visit, unless our office is able to verify chiropractic benefits. Dimond Chiropractic Center checks your benefits with the insurance companies; understand that the benefits quoted are neither a guarantee of payment nor a guarantee of benefits. They are subject to eligibility, deductible and available benefits are the time services are rendered. As a courtesy to you, we will submit all charges to your insurance company. It is important that you understand that your insurance is an arrangement between you and your insurance company. We do not bill Medicare insurance. You're personally responsible for payment of all charges, whether your insurance company pays or not. Co-pays are due at the time services are rendered, unless payment arrangements have been approved in advance.

WORKERS' COMPENSATION: Patients are required to fill out a REPORT OF OCCUPATIONAL INJURY OR ILLNESS with their employer. Once this is completed and verification has been made with the insurer, we will accept assignment.

ACCIDENT AND PERSONAL INJURY (AUTO): Patients are responsible for payment in full at the time of each visit unless our office is able to verify the claim number and Medical Payment coverage for the accident/injury. We do not bill third party insurance. If during the course of your treatment here your medical coverage is exhausted, payment arrangements must be made to keep your account current. If an attorney is retained, please let our office know immediately.

If you have any questions or comments regarding our policy, we will be happy to assist you.

_____

Patient's Signature Date

_____

Representative of Dimond Chiropractic Center Date

Dimond Chiropractic Center

Informed Consent for Chiropractic Treatment

Doctors of chiropractic, medical doctors, and physical therapist who use manual therapy are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

A) While rare, some patient have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
B) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with neurological impairment, and may on rare occasion results in serious injury. The possibility of such injuries resulting from cervical spine adjustment is extremely remote;
C) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or spinal treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributed to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Print Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Witness Signature:_____

Date: _____

Dimond Chiropractic, LLC

Patient Name:_____ Date:_____

Please review the following list of medical problems and mark any that apply to you now or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

Constitutional
□ Recent weight gain: ____ lbs
□ Recent weight loss: ____ lbs
□ Fever or soaking sweats at night
□ Fatigue
□ Weakness/numbness of arms/legs
□ Headaches > 2 times per week
□ Difficulty walking
□ Loss of consciousness/convulsions

Eyes
□ Vision problems not corrected by glasses
□ Glaucoma
□ Eye lens implant
□ Eye prosthesis
□ Contact lenses

Ear, Nose, Throat
□ Chronic stuffy nose or nasal polyps
□ Frequent nose bleeds
□ Sinus problems
□ Hay fever allergies
□ Difficulty hearing
□ Ear infections
□ Hearing aids
□ Chronic sore throat or tonsillitis
□ Hoarseness
□ Difficulty swallowing
□ Dentures or partial plates
□ Capped teeth
□ Loose teeth
□ Orthodontic braces

Cardiovascular
□ Heart murmur
□ Prolapsed mitral valve
□ Heart peacemaker
□ Irregular heartbeat
□ Palpitations or rapid pulse
□ Fainting spells
□ Chest pain or angina on exertion
□ Chest pain or angina at night
□ Heart attack
□ Congestive heart failure
□ Swelling in feet or ankles
□ Shortness of breath lying flat
□ Shortness of breath at night
□ Blood Clots or pulmonary embolism
□ High blood pressure
□ Low blood pressure

Respiratory
□ Asthma or wheezing
□ Bronchitis
□ Emphysema
□ Pneumonia
□ Chronic cough
□ Change in amount of phlegm
□ Change in color of phlegm
□ Coughing up blood
□ Collapsed lung
□ Tuberculosis exposure
□ Blueness of your fingernails

Gastrointestinal
□ Kidney stones
□ Kidney infections
□ Kidney failure
□ Dialysis
□ Prostate problems
□ Bladder infections
□ Blood in urine
□ Difficulty urinating
□ Do you lose your urine at times

Musculoskeletal
□ Fractures or broken bones
□ Arthritis
□ Difficulty opening mouth wide
□ Scoliosis
□ Spinal column deformity

Integumentary/Dermatologic
□ Skin rash or sores
□ Itching
□ Color change, pigmentation, nodules
□ Pressure ulcers

Neurologic
□ Seizures or convulsions
□ Epilepsy
□ Stroke
□ Brain aneurysm or hemorrhage
□ Multiple sclerosis
□ Nerve Injury or numbness

Psychiatric
□ Depression
□ Anxiety or panic attacks
□ Mental disorder

Endocrine
□ Diabetes
□ Insulin use
□ Low blood sugar or hypoglycemia
□ Thyorid problems
□ Steroid use

Allergic/Immunologic
□ Herpes exposure
□ AIDS exposure
□ Street drug use

Hematologic
□ Abnormal bleeding problems
□ Anemia or low blood count
□ Blood transfusion
□ Hemophilia
□ Sickle cell anemia

Lymphatic
□ Swollen glands or masses in axillae, groin
□ Lymphedema

Others
□ Sexual problems
□ Muscular dystrophy
□ Myasthenia gravis
□ Malignant hyperthermia
□ Bad reaction to local anesthetic
□ Down Syndrome
□ Cancer or tumor
□ Chemotherapy
□ Radiation Therapy
□ Recent acute illness
□ Recent hospitalization
□ Recent Surgical operation

For Women Only:
Are you pregnant? □ Yes □ No
Are your menstrual periods normal?
□ Yes □No
□ Bleeding between periods
□ Bleeding after menopause
Number of pregnancies: _____
Date of last menstrual period: _____
Approx date of last pap smear: _____

Reviewed by: _____ Date:_____

Activities of Daily Living Assessment

Rate your current difficulties resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most clearly describes your current degree of difficulty.
1= "I can do it without any difficulty." **2=** "I can do it without much difficulty." **3**= "I manage to do it by myself, despite marked pain." **4** = "I manage to do it despite the pain, but only if I have help." **5**= "I cannot do it all, because of the pain." **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities											
Bathing		Drying hair		Brushing teeth		Putting on Shoes		Preparing meals		Taking out trash	
Showering		Combing hair		Making bed		Tying Shoes		Eating		Doing laundry	
Washing Hair		Washing Face		Putting on shirt		Putting on pants		Cleaning Dishes		Going to toilet	
Difficulties and Physical Activities											
Standing		Walking		Kneeling		Bending back		Twisting left		Leaning back	
Sitting		Stooping		Reaching		Bending Left		Twisting right		Leaning left	
Reclining		Squatting		Bending Forward		Bending right		Leaning forward		Leaning right	
Standing for long periods		Sitting for long periods		Waking for long periods		Kneeling for long periods					
Difficulties with Functional Activities											
Carrying small objects		Lifting weights off floor		Pushing things while seated		Exercising upper body					
Carrying large objects		Lifting weights off table		Pushing things while standing		Exercising lower body					
Carrying brief case		Climbing stairs		Pulling things while seated		Exercising arms					
Carrying large purse		Climbing inclines		Pulling things standing		Exercising legs					
Difficulties with social and Recreational Activities											
Bowling		Jogging		Swimming		Ice Skating		Competitive sports		Dating	
Golfing		Dancing		Skiing		Roller Skating		Hobbies		Dining out	
Difficulties with Traveling											
Driving a motor vehicle		Riding as a passenger in a motor vehicle		Riding as a passenger on a train							
Driving for long periods of time		Riding as a passenger on an airplane		Riding as a passenger for long periods							

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

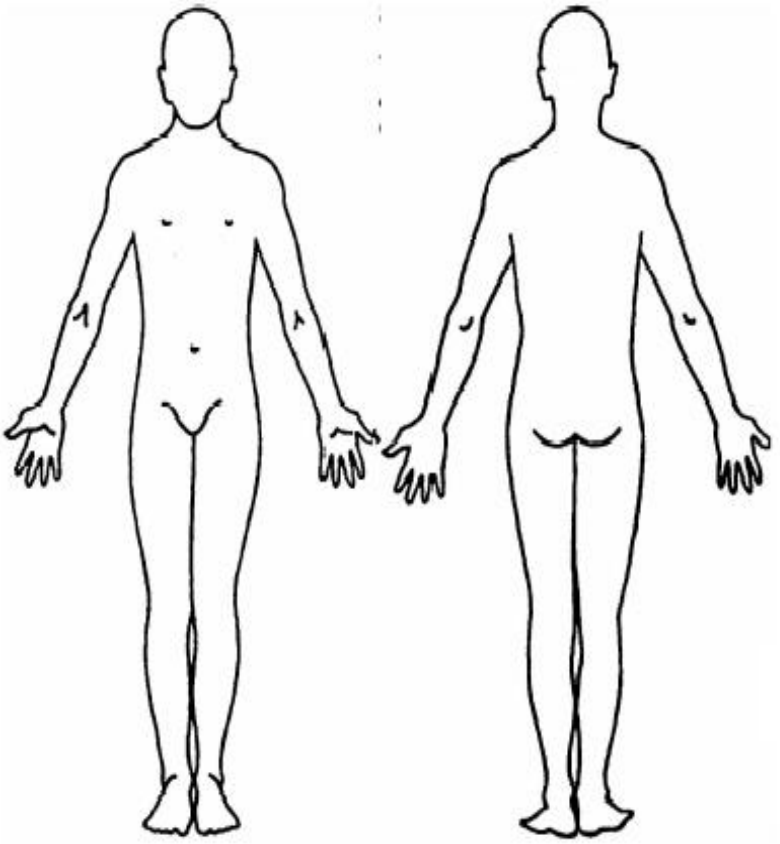
Prior Similar Symptoms	**Has your history contributed to your current symptoms?**
___ I have not had prior symptoms similar to my current complaints ___ My current complaints DID exist before, but have not been bothering me ___ My current complaints ALREADY existed and were worsened	___ My history HAS contributed to my current symptoms. ___ My history HAS NOT contributed to my current symptoms. ___ I'm NOT SURE if my history has contributed to my current symptoms
My most recent prior symptoms (if applicable) occurred ____ months ago / years ago Or on: Date _____/____/_____	
Write in below any other Prior Symptom History, not covered above:	

Patients Signature: _____ Date:_____

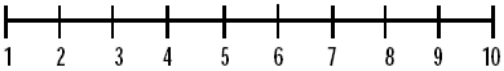
Name:_____ Date: _____

PAIN DIAGRAM

The information you provide on this form will be useful to Dr. Shawn and will help your exam go smoothly . If you are being evaluated for a painful condition, mark the drawings below according to how you feel today. Use the figure labeled “Back” for the pain on the back of your body. If you have any of the symptoms shown in the diagram, indicate where they are by writing in the following letter in the affected area. Please mark the level of pain you experiencing on the 1 to 10 scale. Ten as being the worst and one being no pain



BURNING = B
STABBING = S
PINS & NEEDELS = P
ACHING = A
NUMBNESS = N



MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

_____

_____

_____

2. Phone Number: _____

3. Please describe the collision in your own words:

_____

_____

_____

4. Where did the collision occur? City/Town: _____ State: _____

5. Date of collision: _____ Time: _____ AM PM

6. Were you the: □ driver □ passenger □ pedestrian

7. If passenger, were you in the □ front seat □ right rear seat □ left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? □ yes □ no

11. Was your car struck by the other vehicle? □ yes □ no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: □ the front □ the rear □ the left side □ the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? □ dry □ wet □ icy

17. Was your vehicle in: □ park □ neutral □ in gear □moving □stopped

18. Were your brakes being applied? □ yes □ no

19. Was your vehicle shoved: □ forward □ backward □ sideways

20. Were you shoved: □ forward □ whipped backward

21. Did your seat have a head restraint (headrest?) □ yes □ no

22. If yes, what was the position □ low □ midposition □ high

23. Did your head ride over the headrest? □ yes □no

24. Did your hat/glasses end up in the back seat or rear window? □ yes □ no

25. Did any other part of your body hit the interior of the vehicle? □ yes □ no

26. If yes, please specify: □ seatbelt restraints □ steering wheel □ dashboard

□ windshield □ side door □ side window □ other _____

27. Which part of your body? □ chest □ head □ chin □ face □ R L knee

□ R L shoulder □ R L hand □ other _____

28. Were you holding on to the steering wheel? □ yes □ no

29. Did you brace your arms against the dash? □ yes □ no

30. Did you brace your legs against the floorboard? □ yes □ no

31. Was your ankle turned? □ yes □ no

32. Did the vehicle go into a spin or roll as a result of the impact? □ yes □ no

33. If yes, explain: _____

34. How much damage was there to the outside of the vehicle? □ none □ some □ a lot

35. How much damage was there to the inside of the vehicle? □ none □ some □ a lot

36. At the point of impact, where did you experience pain? Be specific:

_____

_____

37. Immediately after the accident were you: □ conscious □ dazed □ unconscious

38. If you lost consciousness, how long? _____

39. Were you wearing a seat belt? □ yes □ no

40. Did the belt have a shoulder harness? □ yes □ no

41. If yes, did it contribute to the pain you are experiencing? □ yes □ no

42. At the time of impact were you: □ looking straight ahead □ looking to the right

□ looking to the left □ looking down □looking up

43. Did the seat break as a result of the impact? □ yes □ no

44. Were you braced for the impact? □ yes □ no

45. Were you surprised by the impact? □ yes □ no

46. Did you go to the hospital? □ yes □ no

47. If yes, when? □ right after the accident □ next day □ other _____

48. If yes, how did you get there? □ ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: □ neck brace

□ back brace □ other _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? □ yes □ no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

_____

52. Have you had any similar problems before? □ yes □ no

53. If yes, explain: _____

54. Are you diabetic? □ yes □ no

55. Do you have high blood pressure? □ yes □ no

56. Do you have low blood pressure? □ yes □ no

57. Do you have arthritis or degenerative joint disease? □ yes □ no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? □ yes □ no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? □ yes □ no

Name of adjuster handling claim _____

Will company accept assignment of benefits? □ yes □ no

If not, will they make checks payable to patient and our office? □ yes □ no

Limits: How much? $_____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? □ yes □ no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

_____

_____

_____

_____

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? □ yes □ no

In the event of settlement, will they protect any unpaid balance? □ yes □ no

Do they have PIP? □ yes □ no Do we file? □ yes □ no

Do they have insurance? □ yes □ no Do we file? □ yes □ no

Can we file liability? □ yes □ no