

1
one

AUTO / WORK RELATED ACCIDENT

2a

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Name: _____

2b
two b

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ☐ a.m. ☐ p.m.

Was your accident directly related to your work?

☐ Yes ☐ No

Briefly describe the events that occurred just before and during your accident: _____

Give the address where accident occurred: (if other than employer's address) _____

Was anyone else present during your accident?

☐ Yes ☐ No

Did you report your accident to your employer?

☐ Yes ☐ No

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before?

☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before? ☐ Yes ☐ No
In general:

Is your job physically stressful? ☐ Yes ☐ No

Is your job mentally stressful? ☐ Yes ☐ No

Is your workplace noisy? ☐ Yes ☐ No

Have you changed jobs in the last year? ☐ Yes ☐ No

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? . . . ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? . . ☐ Yes ☐ No

If yes, did it/they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

Make & model of the vehicle you were occupying? _____

Name of the location/street on which you were traveling? _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? _____

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

PLEASE CONTINUE ON BACK

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AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance or ☐ Private transportation

Name of Hospital and/or Attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received: _____

Were X-rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury?

☐ Yes ☐ No

Indicate ☒ the symptoms that are a result of this accident:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arms/Shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb Hands/Fingers | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Numb Feet/Toes |

☐ Other _____

Is your condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable even if only sometimes	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom: _____

His/Her Phone #: _____

four

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate ☒ your daily job duties and any activities which you are occasionally asked to perform.

- | | | |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving | <input type="checkbox"/> Operating equipment |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Stooping |

☐ Other _____

What positions can you work in with minimum physical

effort and for how long? _____ ☐ N/A

Prior to the injury were you capable of working on an

equal basis with others your age? . ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any

heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could

request? ☐ Yes ☐ No ☐ N/A

five

ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. . / /

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____/_____/_____
SIGNATURE DATE

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WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: ____

Patient Name: _____
 LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: ____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

2

two

INSURANCE INFO

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

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

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom? _____ Phone#: _____

3

three

PLEASE CONTINUE ON BACK

4

four

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

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five

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? ☐ Yes ☐ No / Exercise? ☐ Yes ☐ No

Are you on a special diet: ☐ Yes ☐ No / Since: ____ / ____ / ____

Do you smoke? ☐ No ☐ Yes / How Much? _____ How Long? _____

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

What is the age of your mattress? ____ Is it comfortable? ☐ Yes ☐ No

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? ____ Nursing? ☐ Yes ☐ No

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ☐ CASH ☐ Check

☐ Credit Card - Enter card # above (if accepted) _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Date ____ / ____ / ____



PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Please describe your condition:

Signature: _____ Date: ____ / ____ / ____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness
Symbol → NNNN

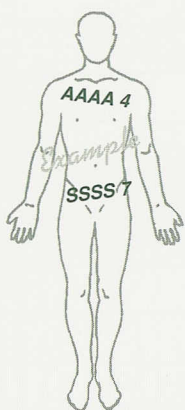
Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

Stabbing
SSSS

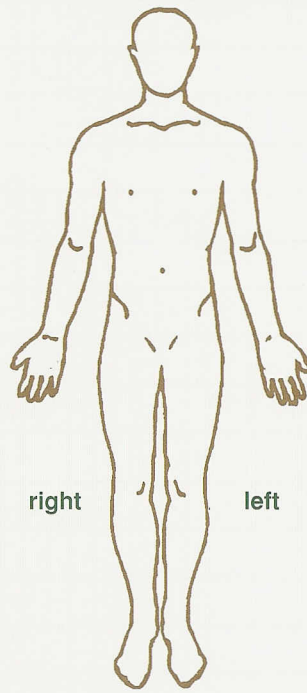
○ Circle any area of pain not represented by a symbol.



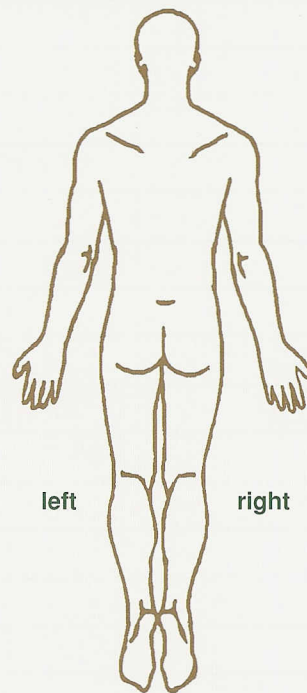
Example



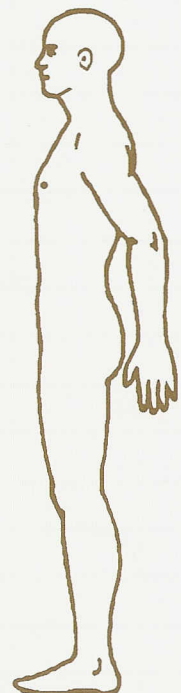
Right



Front




Back



Left

DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET 

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Lacey Chiropractic Clinic, P.A.
Dr. Richard D. Lacey

9428 N. Ocean Highway • PO Drawer 2009 • Pawleys Island, SC 29585

(843) 237-1919

**ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY**

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to Dr Richard D. Lacey/Lacey Chiropractic Clinic P.A.; hereinafter known as "Office", such sums as may be due and owing at this Office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits, medical payment, No-Fault benefits, health and accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payment to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I further agree to assist in and fully cooperate with the Office and its attorneys in their attempts to collect on their charges and services rendered to me for which my insurance carrier and/or attorney has refused to pay. I understand this lien is non-revocable.

I also understand that I remain personally responsible for the total amounts due this Office, and at any time they can demand that I pay all or part of the balance of their fee. I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover. I also agree to pay all the Office's expenses to collect their fee, including a reasonable attorney's fee as well as 21% interest on the balance due beginning with the date of notification that the bill is due.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill. By this agreement, I bind myself, my heirs, executors, administrators and assign benefits to the Office, it's heirs, successors and assigns.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Signed: _____ Date: _____

Witness: _____ Date: _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patient's SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **LACEY CHIROPRACTIC CLINIC, P.A.** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to **LACEY CHIROPRACTIC CLINIC, P.A.** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information, as well as the use of my name on a referral board.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **LACEY CHIROPRACTIC, P.A.** The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **LACEY CHIROPRACTIC CLINIC, P.A.**, for its own use/disclosure of PHI.

(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **LACEY CHIROPRACTIC CLINIC, P.A.** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

UPON REQUEST A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Name _____

Address _____

Signature _____ Date _____

Signature of guardian, if a minor _____ Date _____



Lacey Chiropractic Clinic, P.A.
Dr. Richard D. Lacey

9428 N. Ocean Highway • PO Drawer 2009 • Pawleys Island, SC 29585

(843) 237-1919

PATIENT NAME: _____

TODAY'S DATE: _____

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 (ten) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

	<u>Yes / No / Don't Know</u>		
• I am pregnant	—	—	—
• I could be pregnant	—	—	—
• I am late with my menstrual period	—	—	—
• I am taking oral contraceptives	—	—	—
• I have an IUD	—	—	—
• I have had a tubal ligation	—	—	—
• I have had a hysterectomy	—	—	—
• I have irregular menstrual periods	—	—	—
• My last menstrual period began on _____			

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed now.

Signature

Witness: _____
Signature