



Personal Injury Intake Form and Chiropractic Care Agreement

File Number (Office Use)

Patient Information:

Today's Date
Name
I prefer to be called
Address
Sex
Occupation
Employer
Address

Home Phone
Work Phone
Email
Social Security #
Date of Birth
Height
Weight
Marital Status
No of Children

If minor, name of parent or guardian
Who should we contact in case of an emergency?
Relation
Address
Attorney
Primary Care Physician
How did you hear about our office?
Have you ever been to a chiropractor before?

Health Insurance Information:

Insurance Company
Policy Holder's Name
Address

Policy number
Social Security #
Phone

Auto Insurance Information:

Insurance Company
Address
Adjustor Name

Policy number
Phone
Claim #

Accident Information:

Date
Time
Was a traffic violation issued?
Location of accident
Were there other witnesses?
Please explain in detail how the accident occurred

Was it reported to the police?
To whom?
# of other passengers
Make/model of vehicle you were in

Please list symptoms felt immediately after the accident

In which direction were you headed?
Approx. speed of vehicle MPH

Did the impact to your vehicle come from the:  **FRONT**  **REAR**  **RIGHT**  **LEFT**  **OTHER**

During impact, were you facing:  **RIGHT**  **LEFT**  **FORWARD**

Were you  **AWARE** or  **SURPRISED** by the impact?

Were you the  **DRIVER**  **FRONT SEAT PASSENGER**  **BACK SEAT PASSENGER?**

Were you wearing a seat belt?  **SHOULDER HARNESS**  **LAP HARNESS**

Was the vehicle equipped with air bags?  **YES**  **NO** Did they inflate?  **YES**  **NO**

In relation to the base of your skull, where was the headrest?  **ABOVE**  **BELOW**  **AT BASE**

What did your vehicle impact?  **ANOTHER VEHICLE**  **OTHER** \_\_\_\_\_

If another vehicle, what was the make/model? \_\_\_\_\_ Direction \_\_\_\_\_ Speed \_\_\_\_\_ MPH

Did any part of your body strike anything in the vehicle?  **YES**  **NO** Describe \_\_\_\_\_

Did the accident render you unconscious?  **YES**  **NO** If yes, for how long? \_\_\_\_\_

**Post-Injury Information:**

Have you seen any other doctor(s) since the accident?  **YES**  **NO** Name \_\_\_\_\_

When did you go?  **IMMEDIATELY**  **NEXT DAY**  **2 DAYS PLUS**

How did you get there?  **AMBULANCE**  **PRIVATE TRANSPORTATION**

Name of hospital and/or attending doctor: \_\_\_\_\_

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

Please describe any treatment you received \_\_\_\_\_

Were X-Rays done?  **YES**  **NO** An MRI?  **YES**  **NO** CAT scan?  **YES**  **NO**

Was medication prescribed?  **YES**  **NO** If yes, what? \_\_\_\_\_

Have you missed any work since the accident?  **YES**  **NO** Date(s) \_\_\_\_\_

Are your work activities restricted as a result of your injury?  **YES**  **NO**

Indicate the symptoms that are a result of this accident:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> <b>DIZZINESS</b>      | <input type="checkbox"/> <b>DIFFICULTY SLEEPING</b> | <input type="checkbox"/> <b>JAW PROBLEMS</b>  | <input type="checkbox"/> <b>NAUSEA</b>         |
| <input type="checkbox"/> <b>MEMORY LOSS</b>    | <input type="checkbox"/> <b>ARM/SHOULDER PAIN</b>   | <input type="checkbox"/> <b>IRRITABILITY</b>  | <input type="checkbox"/> <b>BACK PAIN</b>      |
| <input type="checkbox"/> <b>HEADACHE(S)</b>    | <input type="checkbox"/> <b>NUMB HANDS/FINGERS</b>  | <input type="checkbox"/> <b>FATIGUE</b>       | <input type="checkbox"/> <b>LOW BACK PAIN</b>  |
| <input type="checkbox"/> <b>BLURRED VISION</b> | <input type="checkbox"/> <b>TENSION</b>             | <input type="checkbox"/> <b>CHEST PAIN</b>    | <input type="checkbox"/> <b>BACK STIFFNESS</b> |
| <input type="checkbox"/> <b>BUZZING IN EAR</b> | <input type="checkbox"/> <b>NECK PAIN</b>           | <input type="checkbox"/> <b>SHORT BREATH</b>  | <input type="checkbox"/> <b>LEG PAIN</b>       |
| <input type="checkbox"/> <b>EARS RINGING</b>   | <input type="checkbox"/> <b>NECK STIFF</b>          | <input type="checkbox"/> <b>STOMACH UPSET</b> | <input type="checkbox"/> <b>NUMB FEET/TOES</b> |
| <input type="checkbox"/> <b>OTHER</b> _____    |   |   |  |

Did you ever experience similar symptoms prior to the accident?  **YES**  **NO**

Has your condition  **IMPROVED**  **WORSENERD** or  **STAYED SAME** since the accident?

Is your condition affecting your  **WORK**  **SLEEP** or  **DAILY ROUTINE?** Please explain \_\_\_\_\_

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

- |                   |                   |                      |              |
|-------------------|-------------------|----------------------|--------------|
| ___ Lying on Back | ___ Lying on Side | ___ Lying on stomach | ___ Sitting  |
| ___ Standing      | ___ Stretching    | ___ Lovemaking       | ___ Walking  |
| ___ Running       | ___ Sports        | ___ Working          | ___ Lifting  |
| ___ Bending       | ___ Kneeling      | ___ Pulling          | ___ Reaching |

How many hours are in your normal workday? \_\_\_\_\_

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> <b>STANDING</b> | <input type="checkbox"/> <b>OPERATING EQUIPMENT</b>    | <input type="checkbox"/> <b>DRIVING</b> | <input type="checkbox"/> <b>SITTING</b>  |
| <input type="checkbox"/> <b>TWISTING</b> | <input type="checkbox"/> <b>WORK W/ARMS ABOVE HEAD</b> | <input type="checkbox"/> <b>WALKING</b> | <input type="checkbox"/> <b>CRAWLING</b> |
| <input type="checkbox"/> <b>TYPING</b>   | <input type="checkbox"/> <b>LIFTING</b>                | <input type="checkbox"/> <b>BENDING</b> | <input type="checkbox"/> <b>STOOPING</b> |

What positions can you work in with minimum physical effort, and for how long? \_\_\_\_\_

Do you work with others who can help you with any heavy lifting?  **YES**  **NO**

While in recovery, are there any light duty tasks you could request?  **YES**  **NO**

## Health History

Have you ever had any of the following diseases or conditions?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>HEART ATTACK or STROKE</b>    | <input type="checkbox"/> <b>HEART SURGERY or PACEMAKER</b> | <input type="checkbox"/> <b>HEART MURMUR</b>      |
| <input type="checkbox"/> <b>CONGENITAL HEART DEFECT</b>   | <input type="checkbox"/> <b>MITRAL VALVE COLLAPSE</b>      | <input type="checkbox"/> <b>ARTIFICIAL VALVES</b> |
| <input type="checkbox"/> <b>ALCOHOL/DRUG ABUSE</b>        | <input type="checkbox"/> <b>VENEREAL DISEASE</b>           | <input type="checkbox"/> <b>HEPATITIS</b>         |
| <input type="checkbox"/> <b>HIV+/AIDS</b>                 | <input type="checkbox"/> <b>SHINGLES</b>                   | <input type="checkbox"/> <b>CANCER</b>            |
| <input type="checkbox"/> <b>FREQUENT NECK PAIN</b>        | <input type="checkbox"/> <b>EMPHYSEMA</b>                  | <input type="checkbox"/> <b>ANEMIA</b>            |
| <input type="checkbox"/> <b>HIGH/LOW BLOOD PRESSURE</b>   | <input type="checkbox"/> <b>PSYCHIATRIC PROBLEMS</b>       | <input type="checkbox"/> <b>RHEUMATIC FEVER</b>   |
| <input type="checkbox"/> <b>SEVERE/FREQ. HEADACHES</b>    | <input type="checkbox"/> <b>KIDNEY PROBLEMS</b>            | <input type="checkbox"/> <b>ULCERS/COLONITIS</b>  |
| <input type="checkbox"/> <b>FAINTING/SEIZURE/EPILEPSY</b> | <input type="checkbox"/> <b>SINUS PROBLEMS</b>             | <input type="checkbox"/> <b>ASTHMA</b>            |
| <input type="checkbox"/> <b>DIABETES</b>                  | <input type="checkbox"/> <b>DIFFICULTY BREATHING</b>       | <input type="checkbox"/> <b>TUBERCULOSIS</b>      |
| <input type="checkbox"/> <b>LOWER BACK PROBLEMS</b>       | <input type="checkbox"/> <b>ARTIFICIAL BONES/JOINTS</b>    | <input type="checkbox"/> <b>ARTHRITIS</b>         |

Please list **any other** medical conditions that you have or have ever had. \_\_\_\_\_

Please list any allergies. \_\_\_\_\_

Please list previous surgeries and dates. \_\_\_\_\_

Please list any past motor vehicle accidents or traumas and dates. \_\_\_\_\_

Is there anything else about your health history or family health history that you feel is important to share? \_\_\_\_\_

Do you exercise?  **YES**  **NO**

Are you on a special diet?  **YES**  **NO** Since: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you smoke?  **YES**  **NO** How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing:  **ORTHOTICS**  **HEEL LIFTS**  **ARCH SUPPORTS**

*For women:* Are you taking birth control?  **YES**  **NO**

Are you pregnant?  **YES**  **NO** How long? \_\_\_\_\_ Nursing?  **YES**  **NO**

**Patient/Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



## **ASSIGNMENT OF INSURANCE BENEFITS**

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

I hereby authorize payment to be made directly to FOX Spine & Sports Medicine , of all benefits which may be due and payable under insurance coverage for the above named Patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to FOX Spine & Sports Medicine .

Furthermore, I hereby IRREVOCABLY ASSIGN to FOX Spine & Sports Medicine , the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida statutes for any service and or charges provided by FOX Spine & Sports Medicine .

Signature of Patient or responsible party: \_\_\_\_\_

Signature of witness: \_\_\_\_\_



## **OFFICE POLICIES**

**The following are FOX Spine & Sports Medicine 's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.**

**Consent for Treatment.** The Patient and/or the undersigned, give PBFCSM and Dr. Christopher Fox my/our permission to evaluate and treat the Patient's injury or condition. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of evaluation, care treatment.

**Appointment Scheduling and Cancellation Policy.** At FOX Spine & Sports Medicine , we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

**Office Visits.** We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings!

**Private Health Insurance.** I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

**Patient/Parent or Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**DISPUTE RESOLUTION**

**Arbitration.** The undersigned and the Patient agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by FOX Spine & Sports Medicine and/or Dr. Christopher Fox (jointly, "PBFCSM"), shall be resolved exclusively by binding arbitration pursuant to the Florida Arbitration Code, Florida Statutes 682. This includes any injury or losses by you or your children on the premises. Arbitration shall occur in West Palm Beach, Florida and nowhere else.

**County Court Exception.** The undersigned, the Patient, and PBFCSM all agree that any dispute or claim arising from or relating to the office visit(s) and/or the care provided by PBFCSM which is within the monetary jurisdiction of county court, Florida Statute 34.01(1)(c), may be brought in arbitration as set forth above or Palm Beach County Court and nowhere else.

**Severability/Jury Waiver.** In the event any portion of this Chiropractic Care Agreement is deemed unenforceable, that portion shall be severed and all other provisions remain in full force and effect. The undersigned, the Patient, and PBFCSM agree that each has waived its rights to a jury trial for any disputes or claims among them.

**Chiropractic Care.** The undersigned and the Patient agree and acknowledge that PBFCSM provides chiropractic care only. The Patient is advised and agrees to consult a medical doctor routinely and as needed. Please ask questions about your health!

**Patient/Parent or Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Receipt of Notice of Privacy Practices**  
**Written Acknowledgement Form**

I, \_\_\_\_\_ have read a copy of **FOX Spine and Sports Medicine & Sports Medicine's** notice of Patient Privacy Practices.  
Patient Name

\_\_\_\_\_  
Signature of Patient or Parent or Legal Guardian      Date



## **CHIROPRACTIC INFORMED CONSENT**

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from FOX Spine & Sports Medicine and Dr. Christopher Fox (jointly, "PBFCSM").

Dr. Fox is a "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods. See Florida Statute 460.403(3)(b).

**Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine.** The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. See Fla.Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. See Fla.Stat. 460.403(9)(a).

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by PBFCSM. I hereby give my informed consent to receive chiropractic medicine from PBFCSM.

\_\_\_\_\_  
Patient Name/Signature (and date)

\_\_\_\_\_  
Guardian/Parent's Name/Signature (and date)