# PATIENT INFORMATION / *PIP*

HARBOR LIFE CHIROPRACTIC

First Name:_____
Middle Name:_____
Last Name:_____
Street:_____
City:_____
State:_____ Zip:_____
Cell Phone:_____
Home Phone:_____
Email:_____

Name of insured(if different):_____
Street:_____
City:_____ State:_____ Zip:_____

Do you have any concerns with the following?:
☐ Weight ☐ Nutrition ☐ Sleep
☐ Fitness ☐ Healthy aging

DOB:_____/_____/_____ Gender: ☐ **Male** ☐ **Female**

Marital Status: ☐ **Single** ☐ **Married** Spouse:_____
☐ **Widowed** ☐ **Divorced** ☐ **Separated**

SSN:_____-_____-_____

How did you hear about us?: ☐ **Internet search** ☐ **Facebook** ☐ **Phonebook** ☐**Physician**
☐ **Friend/Family** ☐ **Existing Patient** (Name:_____)
☐ **Walk-by** ☐ **Other**:_____

Emergency contact:_____ Phone number:_____

Personal Insurance Company:_____ Claim#:_____
Adjuster:_____ Phone Number:_____
Name on Policy:_____
Has the accident been reported to the Insurance Company?: ☐ **Y** ☐ **N**
Date of Accident: _____/_____/_____ Time:_____ A.M./P.M. Number of Passengers:_____
Has an Attorney been retained?: ☐ **Y** ☐ **N** *If yes, Name of Attorney*:_____
Attorney City:_____ Phone:_____
Have you lost any days of work?: ☐ **Y** ☐ **N** Dates:_____
Have you had similar accidents before?: ☐ **Y** ☐ **N** *If yes, when?*:_____

**SYMPTOMS YOU'VE NOTICED SINCE THE ACCIDENT:**

| | | |
|---|---|---|
| ☐ Headaches | ☐ Shortness of breath | ☐ Cold hands |
| ☐ Chest pain | ☐ Numbness in fingers | ☐ Hip pain |
| ☐ Pins and needles in legs | ☐ Neck pain | ☐ Loss of balance |
| ☐ Dizziness | ☐ Light bothers eyes | ☐ Tension |
| ☐ Fatigue | ☐ Nervousness | ☐ Pain down legs |
| ☐ Pins and needles in arms | ☐ Mid-back pain | ☐ Loss of smell |
| ☐ Ringing in ears | ☐ Loss of memory | ☐ Fainting |
| ☐ Depression | ☐ Cold feet | ☐ Tight muscles |
| ☐ Numbness in toes | ☐ Low-back pain | ☐ Head seems too heavy |
| ☐ Stiff neck | ☐ Loss of sleep | ☐ Irritability |

Major Complaint:_____
When did your symptoms begin?: _____/_____/_____
Did you have any of these symptoms before the accident?: ☐ **Y** ☐ **N**
Primary Care Physician:_____ Phone:_____
May we contact him/her regarding your care?: ☐ **Y** ☐ **N** Other Doctors seen for this condition:_____
Operations on your Neck or Back?: ☐ **Y** ☐ **N** When?:_____ *Female* – Are you Pregnant?: ☐ **Y** ☐ **N**
List any medications you are taking:_____

_____ _____/_____/_____
Signature Date

# CHECK THE BOX NEXT TO THE APPROPIATE EXPLANATION

What was your position in the vehicle?
☐ The Driver
☐ The front passenger
☐ The rear passenger
☐ A pedestrian

What type of vehicle were you driving?
☐ Compact
☐ Mid size
☐ Full size
☐ Other_____

What speed were you traveling at the time of the accident?
☐ Complete Stop
☐ Slowly merging into traffic
☐ Slowing at an intersection
☐ Other _____
☐ Approximate mph _____

Who hit who?
☐ Was struck by another vehicle
☐ Struck another vehicle
☐ Struck a stationary object

What was your vehicles point of impact?
☐ Front: right, left, middle
☐ Rear: right, left, middle
☐ Side: right front, right rear, right middle
☐ Side: left front, left rear, left middle

What speed was the other vehicle traveling?
☐ Complete stop
☐ Slowly merging into traffic
☐ Slowing at an intersection
☐ Other_____
☐ Approximate mph _____

What was the other vehicles point of impact?
☐ Front: right, left, middle
☐ Rear: right, left, middle
☐ Side: right front, right rear, right middle
☐ Side: left front, left rear, left middle

Were you wearing seat restraints?
☐ Was wearing full shoulder and lap restraints
☐ Was wearing only shoulder restraints
☐ Was wearing only lap restraints
☐ Wasn't wearing any seat restraints

Did your vehicles airbag deploy?
☐ Airbag did deploy
☐ Airbag did not deploy

Were you prepared for the impact?
☐ Was entirely surprised by the accident
☐ Saw the collision coming
☐ Saw the collision coming and braced appropriately

What position was your body in just prior to the impact?
☐ A straight position
☐ A tilted forward position
☐ A position rotated to the right
☐ A position rotated to the left
☐ A position that cannot be remembered

What happened to your body at the moment of impact?
☐ Body was tensed for impact
☐ Body whipped violently forward and backward
☐ Body violently torqued and twisted
☐ Body thrown over the seat
☐ Body thrown from the vehicle
☐ Body was pinned in the vehicle
☐ Body was thrown violently from side to side
☐ Body was badly cut and bruised

What was your mental/emotional state immediately following the accident?
☐ Was not rendered unconscious by the accident
☐ Was not rendered unconscious but was shaken and disoriented
☐ Was not rendered unconscious but was shaken up
☐ Was rendered unconscious by the impact of the accident

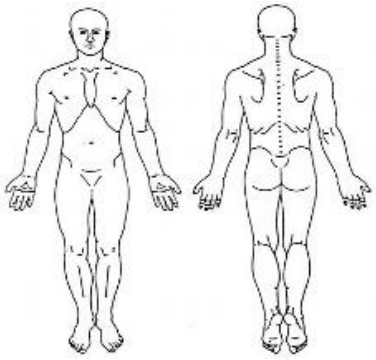
Did you receive medical attention at the scene of the accident?
☐ Did receive medical attention
☐ Did not receive medical attention

Where did you go immediately following the accident?
☐ Was taken to a hospital
☐ Was taken home
☐ Was taken to a personal physician
☐ Was taken to this office
☐ Resumed activities

List each of your body parts that struck the following vehicle parts during the accident:
Dashboard _____
Windshield _____
Steering Wheel _____
Right Door _____
Left Door _____
Seat Frame _____
Unknown Object _____

**MARK PAIN AREAS**

+++ Burning
OOO Stabbing
- - - Sharp
I I I Constant



_____
Signature

_____/_____/_____
Date

HARBOR LIFE CHIROPRACTIC

## ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this 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 doctor's 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. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

**Patient (or) Guardian Signature:**_____

**Date:** _____/_____/_____

## CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; I furthermore authorize him to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

**Patient (or) Guardian Signature:**_____

**Date:** _____/_____/_____

## INSURANCE INFORMATION

*We will make a copy or your insurance card(s). However, please complete as much of the following information as you can.*

Insurance:_____ ID#:_____ Group#:_____

Effective Date:_____/_____/_____ End Date: _____/_____/_____ Copay: $_____ Deductible: $_____

**Are you the policyholder?** ☐ **Y** ☐ **N**

If no, what is your relation to them?: ☐ **Spouse** ☐ **Parent** ☐ **Other:**_____

Policy Holder's Full Name:_____ Policy Holder's DOB:_____/_____/_____

Address:_____ Policy Holder's Employer:_____

**Secondary Insurance (if any):**

Insurance:_____ ID#:_____ Group#:_____

Effective Date:_____/_____/_____ End Date: _____/_____/_____ Copay: $_____ Deductible: $_____