Kilkenny Chiropractic, LLC

History involving Accident or Trauma

Name: _____ Today's date: _____

Date of birth: _____ Gender: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Please circle your preferred phone number for communications from our office.

Single Married Divorced Widowed Spouse's name: _____ Children Yes No Ages: _____

Occupation: _____ Full-time Part-time Retired Unemployed Disabled

Employer: _____

Student: Full-time Part-time School/Major: _____

Insurance: _____ Insured's Name: _____

Insured's date of birth: _____ Relationship to insured: _____

Insured's address (if different from the patient's): _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Last seen (month/year): _____

How did you hear about our office? _____

Have you seen a chiropractor before? yes no Comments: _____

_____

Has any imaging been done for your injuries? Yes No X-ray MRI CT Body part(s): _____

_____

Name: _____ Date of accident/injury: _____

Please describe how the accident/injury occurred: _____

_____

_____

If motor vehicle collision: Year _____ Make _____ Model _____ (vehicle patient was in)

Year _____ Make _____ Model _____ (other vehicle involved)

Were you the: Driver Front passenger Rear left passenger Rear middle passenger Rear right passenger

What was your body position at impact? _____

At the time of impact, were you wearing a seatbelt? Yes No Were you aware the impact was coming? Yes No

Did your vehicle have airbags? Yes No If yes, did they deploy? Yes No

Damage to your vehicle: Mild Moderate Totaled Unknown

Did the police come to the scene of the accident? Yes No Is there a police report? Yes No

Where was your vehicle struck? Front Rear Left side Right side _____

Did your vehicle strike another object **after the initial impact** (vehicle, pole, tree, barrier, etc.)? Yes No

Explain if "yes": _____

Did any part of your body strike anything within your vehicle at impact? Yes No

Explain if "yes": _____

Did you lose consciousness because of this accident? Yes No Unsure If yes, how long? _____

Have you felt dazed/confused or had memory/concentration issues? Yes No If yes, how long? _____

Please circle **all** of your symptoms **immediately after the impact**: Neck pain Mid back pain Low back pain

Headache Dizziness R/L shoulder/arm/hand pain Chest pain R/L hip/leg/foot pain _____

Please circle **all** of your symptoms **later that day or week**: Neck pain Mid back pain Low back pain

Headache Dizziness R/L shoulder/arm/hand pain Chest pain R/L hip/leg/foot pain _____

Please circle **all** of your symptoms **today**: Neck pain Mid back pain Low back pain

Headache Dizziness R/L shoulder/arm/hand pain Chest pain R/L hip/leg/foot pain

Additional symptoms: _____

Did you go to an ER/Urgent Care? Yes No If yes, where/when? _____

_____

How did you get there? Ambulance Private Transportation Other: _____

Name: _____ Date of birth: _____

Have you received care from any other health care provider before today's appointment? Yes No

If yes, explain: _____

Were you suffering from any of the above symptoms before this trauma? Yes No

If yes, explain: _____

Previous accidents/trauma that may be causing/contributing to your symptoms? Yes No

If yes, explain: _____

Any trauma since this accident that may be causing/contributing to your symptoms? Yes No

If yes, explain: _____

How have you been treating your symptoms: Ice Heat Rest Medication Massage TENS unit

Stretching Topical creams (Biofreeze, Icy Hot, arnica, etc.) Other: _____

Are you having trouble **falling** asleep? Yes No **staying** asleep? Yes No Nightmares? Yes No

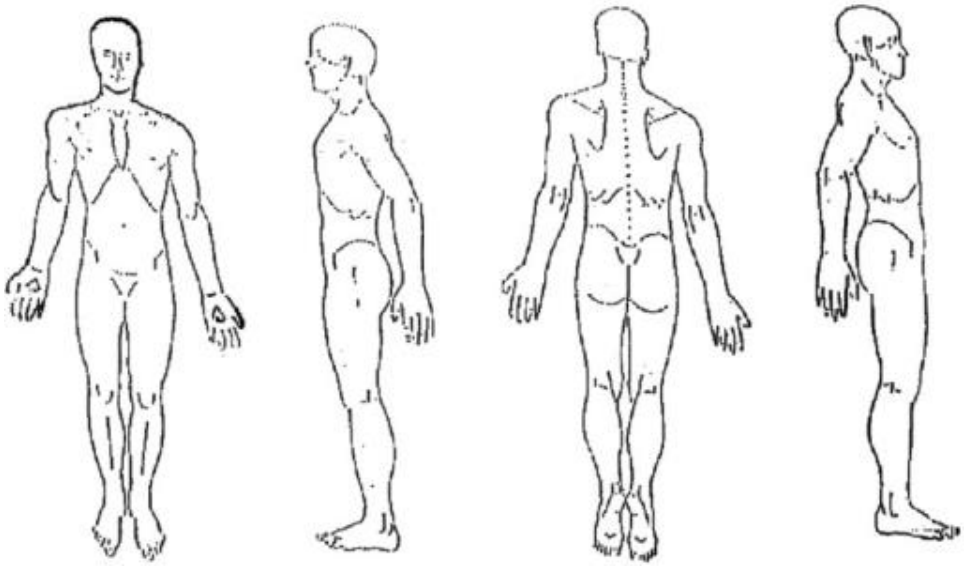
Are you having any flashbacks of the accident? Yes No

Are you able to drive/ride in a car without an increase in anxiety? Yes No

Have you lost any time from work/school due to these injuries? Yes No How much? _____

Do you have any work/school restrictions? Yes No Explain: _____

Please mark all areas where you have pain



Health History Information Sheet

Patient Name: _____ Today's date: _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____lbs. Left Right handed

Past Medical History: Please mark <u>all</u> that apply to ***you*** with a "C" (current) or "P" (past).

	High Blood Pressure		Stroke TIA		Diabetes Type I or II		Osteopenia / porosis
	Heart Condition		DVT / blood clots		Dizziness Vertigo		Migraines Headaches
	High Cholesterol		Marfan's Syndrome		Scoliosis		Circulatory Condition
	Kidney Disease		Ehlers-Danlos		Thyroid Condition		Arthritis
	Autoimmune Disease		HIV or AIDS		Reflux		IBS / UC
	Hepatitis - Type ___		Anxiety PTSD		Depression		Epilepsy Seizures
	Neurological Disease		Fibromyalgia		Tinnitus Hearing issues		Visual problems
	Respiratory Condition		Nausea Vomiting		Peripheral Neuropathy		Skin Condition
	Unexplained weight loss		Hair loss		Loss of: smell taste		Urinary Issues
	Reproductive issues		Concussions # ____		Physical/Emotional Abuse		Cancer

Other: _____

Please explain positive responses above: _____

_____

Tobacco Use: Never/In the past/Presently How much: _____ How long: _____ Year quit: _____

Alcohol use: Daily/Weekly/Rarely/None Other substance use or abuse: yes no _____

Current medications/supplements: _____

ANY serious traumas/MVA/illnesses: _____

ANY surgeries/allergies: _____

Family Medical History: Please mark <u>all</u> that apply to your ***immediate family*** only (grand/parents/siblings).

	High Blood Pressure		Stroke TIA		Diabetes Type I or II		Osteopenia / porosis
	Heart Condition		DVT / blood clots		Dizziness Vertigo		Migraines Headaches
	High Cholesterol		Marfan's Syndrome		Scoliosis		Circulatory Condition
	Kidney Disease		Ehlers-Danlos		Thyroid Condition		Arthritis
	Autoimmune Disease		HIV or AIDS		Reflux		IBS / UC
	Hepatitis - Type ___		Anxiety PTSD		Depression		Epilepsy Seizures
	Neurological Disease		Fibromyalgia		Tinnitus Hearing issues		Visual problems
	Respiratory Condition		Nausea Vomiting		Peripheral Neuropathy		Skin Condition
	Unexplained weight loss		Hair loss		Loss of: smell taste		Urinary Issues
	Reproductive issues		Concussions # ____		Physical/Emotional Abuse		Cancer

Other: _____

Please explain positive responses above: _____

Patient Name: _____ Date of birth: _____

I hereby attest that the above information is true and accurate to the best of my knowledge. I hereby authorize Dr. Elizabeth Whooley to examine me.

_____ _____

Patient's printed name Date

_____ _____

Patient's signature Parent/guardian if for a minor

_____

For the doctor's use only below this line.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Notice to All Patients

Welcome to our practice! We strive to provide you with excellent chiropractic care. We ask for your help by reading and cooperating with our patient and financial policies as outlined below.

- Please sign in upon entering the facility for your scheduled appointment. Please let us know if your insurance, address, or any other personal information has changed.
- All payments are due at the time of service: Self-pay fees, Insurance co-payments, and deductibles.
- Any open balances such as co-insurances and deductibles will be collected on the day of service. Charges are payable by cash, check, Visa, MasterCard, Discover or American Express.
- A returned check will result in a $25.00 service charge and all future payments will be collected in the form of cash or credit card.
- Refund requests may take up to 4 (four) weeks from the date requested, if there are no pending claims.
- Any balance over 90 days old will be processed and sent to a collection agency.
- Our practice participates with United Healthcare, Medicare, and VA CCN; it is your responsibility to understand the requirements and covered benefits of your plan. **We will bill your insurance company as a courtesy, but it is your responsibility to follow up on all insurance issues.** The billing department will do everything that can be done to resolve insurance issues, but it is your responsibility in the end as you are their subscriber.
- You are responsible for any non-covered and/or denied claim; you will receive a statement of denied charges and payment is due within 30 (thirty) days after the date on the statement.
- If your insurance policy requires a referral, it is your responsibility to contact your primary care physician and have a referral sent to our office prior to your appointment date.
- **Failure to notify the clinic of needing to cancel your scheduled appointment with at least 24 hours advanced notice will result in a $25.00 charge billed directly to you.** Your insurance company will **NOT** cover this fee.
- We value your time. If you have a limited amount of time for your scheduled appointment, please let us know in advance or upon arrival in our facility so that we are able to accommodate you the best that we can.
- In order to provide all of our patients with proper care, it is imperative that you arrive on time for your scheduled appointment. Please call the office as soon as you know that you will be arriving late for your appointment so that we can prepare for this change. You may have to wait to be seen depending on the other scheduled appointments for that day.

Thank you for your patience and cooperation. By signing below, you acknowledge and certify that you have read, understood, and agreed to the patient policies as listed above. We realize that temporary financial problems may affect timely payment of accounts. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. Please call the office at (407)707-5234.

I have read and understood the above Patient and Financial Policies and agree to all listed obligations.

_____ _____

Patient Signature Date

Kilkenny Chiropractic, LLC

1945 W County Road 419, Suite 1111

Oviedo, FL 32766

(407) 707-5234

I, _____, in exchange for medical services, assign all rights, title, and interest from any and all automobile insurance policies, which provide medical benefits or no-fault benefits to Kilkenny Chiropractic for services rendered to me by Kilkenny Chiropractic, LLC related to injuries sustained in an automobile accident which occurred on or about _____.

Additionally, I agree to fully cooperate with Kilkenny Chiropractic, LLC and do nothing to impair its rights, title, and interest under the policy. I further authorize my insurance company to release any information that Kilkenny Chiropractic, LLC deems necessary for the pursuit of its claim for benefits under any policy of insurance.

_____ _____

Patient's signature Date

The undersigned, as an authorized representative of Kilkenny Chiropractic, LLC accepts the assignment of benefits as set forth above.

_____ _____

Authorized representative of Kilkenny Chiropractic, LLC Date

Kilkenny Chiropractic, LLC

1945 W County Road 419, Suite 1111

Oviedo, FL 32766

(407) 707-5234

Informed Consent

Doctors of chiropractic, medical doctors, osteopathic physicians, and physical therapists using manual therapy treatments for patients with neck problems are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause strokes, sometimes with serious neurological injury. The chances of this happening are extremely remote. Appropriate tests will be performed to help identify if you may be susceptible to that kind of injury and an appropriate response will occur. Additionally, there is a risk of soreness following the examination and/or treatment. Certain health conditions, medications (ex. steroids, fluoroquinone), and smoking increase your risk of fracture and stroke so please be thorough and truthful with your health history. If you have any comments or questions about this, please speak with Dr. Whooley.

I have read and understood the above statement, accept the mentioned risk, and hereby consent to treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for 6 (six) years.

By completing the lines below, I _____ authorize being contacted for practice reminders, information, and changes by:

Email at: _____

Phone call at: _____ 2nd number: _____

Permission to leave a voice message? Yes No Permission to send a text message? Yes No

_____ _____

Patient's printed name Date

_____ _____

Patient's signature Parent/guardian if for a minor

List below the names and relationships of people to whom you authorize Kilkenny Chiropractic, LLC to release Protected Health Information (PHI). This allows us to acknowledge that you are being treated here, discussion of your condition, and/or allow them to pick up records on your behalf.

_____ _____

_____ _____

I hereby attest that the above information is true and accurate to the best of my knowledge. I hereby authorize the doctor or her representative to examine and treat me for my injuries/symptoms and related illnesses as they deem appropriate. **I understand that fees for professional services from Kilkenny Chiropractic, LLC are due and payable at the time of the visit**, unless other arrangements have been made. I understand that copies of my office records are available and may be obtained by filling out and signing the appropriate medical release form, and that there may be a fee for this service, not to exceed the usual and customary rates.

I understand and agree that health insurance and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that as a courtesy, Kilkenny Chiropractic, LLC will assist me in submitting my bills to the insurance carrier and in making collections from the insurance company, and that any amount authorized to be paid directly to Kilkenny Chiropractic, LLC will be credited to my account upon receipt. However, **by affixing my signature below, I agree that I am personally responsible for full payment of all goods and services rendered me through this clinic**, regardless of the type and amount of insurance reimbursement provided for these services from third party payors.

_____ _____

Patient's printed name Today's date

_____ _____

Patient's signature Signature of parent/guardian for minor