P 302 407 3549 • F 302 515 0768 • WilmingtonChiroCare@Gmail.com

305 N Union Street, Suite 110, Wilmington, Delaware 19805

New Patient Intake Form

Today's Date

Patient Name

First Name

Date of Birth

SS #

SS Number

Address

Phone *

Phone

Emergency

contact number

Test(s) Ordered

Health Insurance ID Number

Did you report this accident to your car insurance?

Motor Vehicle Carrier (List your car insurance)

MVA Claim Number (List claim # your insurance gave you)

Date of Injury & State

Worker's Comp Carrier

WC Claim Number

Adjuster Name & Phone Number

Attorney Fax Number

Referring Contact Name

Wilmington Chiropractic Care

Patient Name

Date

Address

City

State

Date of Birth

Social Security Number

Spouse Name

Spouse Age

Children's Names and Ages

Name of Employer

Occupation

Health Insurance Name

Policy/Claim Number

Name of Previous Chiropractors

Who Referred You

Attorney

Reason for Coming In

What Accidents Have You Had (include dates)

List Any Fractures, Major or Minor Surgeries You Had (include dates)

Present Medications

Patient Signature:

Clear

New Patient Questionnaire – Auto-Accident

Patient Name

Today's Date

Date Accident Occurred or Started

Time of Day when Accident Occurred or Started

Describe how the Accident took place

Describe the condition or symptoms caused by the Accident

Auto-Accident Specific Information

Were you the

- [ ] Driver
- [ ] Passenger
- [ ] Pedestrian
- [ ] Bicyclist

Automobile you were in

Year Value

Make Value

Model Value

Damage to your car

- [ ] Front
- [ ] Rear
- [ ] Pedestrian
- [ ] Driver Side
- [ ] Passenger Side
- [ ] Bumper
- [ ] Fender
- [ ] Minor
- [ ] Major
- [ ] Totaled
- [ ] Moderate
- [ ] Unsure

Damage Amount Estimate

$ Value

Other Automobile

Year Value

Make Value

Model Value

Damage to other car

- [ ] Front
- [ ] Rear
- [ ] Pedestrian
- [ ] Driver Side
- [ ] Passenger Side
- [ ] Bumper
- [ ] Fender
- [ ] Minor
- [ ] Major
- [ ] Totaled
- [ ] Moderate
- [ ] Unsure

Where did the accident happen?

Street Names	Value
City/State	Value

Was it?

- [ ] Controlled Intersection
- [ ] Uncontrolled
- [ ] Not Intersection

Was there a traffic light?

- [ ] None
- [ ] Green
- [ ] Red
- [ ] Turn Arrow
- [ ] Stop Sign

Were you?

- [ ] Slowly Moving
- [ ] Moving
- [ ] Stopped

Weather Conditions

- [ ] Sunny
- [ ] Rainy
- [ ] Cloudy

Street Surface

- [ ] Dry
- [ ] Wet
- [ ] Slick
- [ ] Icy
- [ ] Pavement
- [ ] Other(specify)

Other

Type of Impact

- [ ] Rear End
- [ ] Front
- [ ] Side Impact
- [ ] Roll Over

Brakes on Impact

- [ ] Locked Tied
- [ ] Loosely Applied
- [ ] Foot not on break

How far did your car move?

- [ ] Did not move
- [ ] Moved 1-5 ft
- [ ] Moved 6-10 ft
- [ ] Moved over 10 ft

Where were you seated in the vehicle?

Wearing Seat Belt?

- [ ] Yes
- [ ] No

Shoulder harness

- [ ] Yes
- [ ] No

Headrest Position

- [ ] Up
- [ ] Down

Is the car equipped with airbags?

- [ ] Yes
- [ ] No

Did they deploy?

- [ ] Yes
- [ ] No

Did you see the impact coming?

- [ ] Yes
- [ ] No

Did you brace yourself for impact?

- [ ] Yes
- [ ] No

On impact, your head was looking

- [ ] Ahead
- [ ] Behind
- [ ] Up
- [ ] Down
- [ ] To the Right
- [ ] To the Left

On impact were you

- [ ] Thrown forward
- [ ] Thrown backwards
- [ ] Thrown sideways
- [ ] Other/Specify

Other

Did your body hit anything inside the car?

- [ ] Yes
- [ ] No

If Yes, What Part of the Body?

What did it Hit?

Head trauma?

- [ ] Yes
- [ ] No

Loss of Consciousness?

- [ ] Yes
- [ ] No

For How Long?

Do you remember the accident happening?

- [ ] Yes
- [ ] No

Hospital?

- [ ] Yes
- [ ] No

Name of Hospital

How long there?

Taken by ambulance?

- [ ] Yes
- [ ] No

X-rays taken?

- [ ] Yes
- [ ] No

X-ray areas

- [ ] Neck
- [ ] Mid-Back
- [ ] Low-Back
- [ ] Other X-rays

Other

Medication Given?

- [ ] Yes
- [ ] No

RX

Other Instruction

Follow-up

Additional Information Related to the Condition:

Describe your pain

- [ ] Sharp
- [ ] Dull
- [ ] Stabbing
- [ ] Aching
- [ ] Radiating
- [ ] Burning

- [ ] Throbbing
- [ ] Numbness

What caused it?

What aggravates it?

What relieves it?

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence?

Yes Value

Type Value

When?

Describe

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name

Type of Licensure

Date of Last Visit

Have you missed work or school due to your injuries?

- [ ] Yes
- [ ] No

Do you smoke?

- [ ] Yes
- [ ] No

If Yes, Number of Packs

Do you drink?

- [ ] Yes
- [ ] No

If Yes, Number of Drinks

Notes

Medical History:

Have you ever been in our office before?

- [ ] Yes
- [ ] No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1 Value

2 Value

3 Value

Surgeries/Hospitalizations

Allergies (please list all)

List all medications you are now taking and why

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INFORMED CONSENT TO TREAT

Please read this ENTIRE section prior to signing. It is important that you understand the information contained in this section. If anything is unclear, please ask questions before you sign.

DO NOT SIGN THIS CONSENT TO BE TREATED UNTIL YOU HAVE READ, UNDERSTAND AND ASKED ANY QUESTION YOU MAY HAVE!

Chiropractic Manipulation and Therapy Risks:

As with any healthcare procedure, there are certain complications which may arise during or after chiropractic manipulation of the spine and/or extremities and with the use of physical therapy treatments. These complications include but are not limited to: **fracture of bones, spinal disc injuries, joint dislocations, muscle injuries, nerve injury, rib injuries, and worsening symptoms.** These

complications are generally described as rare. Manipulation of the neck has been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million or more neck adjustments. Having been informed of these risk factors, I hereby attest that I understand the terms used in the above paragraph and give my consent for chiropractic treatment.

Patient/Guardian Name Printed

Date

Patient/Guardian Name Signature

Clear

Relationship to Patient

I have addressed any questions regarding consent to treat:

Doctor Signature

Clear

Name

Date

RELEASE OF RECORDS

I, do hereby authorize Wilmington Chiropractic Care, LLC to release my medical and billing records to any of its billing companies, attorneys, adjusters, etc. for the sole purpose of getting my bill paid.

Patient Signature

Clear

Date

CONSENT TO TREAT

I, hereby authorize Wilmington Chiropractic Care, LLC and assistants to perform medical examination, physical therapy, chiropractic care, and diagnostic testing on me.

Patient Signature

Clear

Date

ASSIGNMENT OF BENEFITS

I understand that my insurance company may not accept assignment. I understand that my insurance company may pay me directly for the services rendered to me from Wilmington Chiropractic, LLC. I also understand that it is my responsibility to forward these checks and all explanation of benefits to Wilmington Chiropractic Care, LLC immediately upon receipt. I understand that it is illegal for me to cash or deposit the insurance check that I receive for services from these providers, particularly when I have not paid for the services personally. I understand that if I fail to forward the checks for these services, it will be my responsibility to pay my balance in full for all services provided to me. I know that I will be given five business days to settle my account before legal proceedings begin. If my account is not settled, I will also be responsible for any additional costs, such as court and legal fees. I understand that services provided to me today may be issued on more than one check, and I agree to forward ALL checks regarding todays and future treatment to Wilmington Chiropractic Care, LLC. I willingly sign this agreement,

Patient Signature

Clear

Date

POWER OF ATTORNEY

I expressly authorize and give power of attorney to Wilmington Chiropractic Care, LLC and its billing agents, for the signing and completing of any form in the completion of my claims and endorsing any checks made payable to me, in support of processing or making payment of claim for any charges incurred by me at these offices. Further, these offices acknowledge that they are only entitled to receive payment for only those charges, which were incurred through their office, and any overpayment will be refunded appropriately and timely.

Patient Signature

Clear

Date

Wilmington Chiropractic Care

Submit