Springfield Family Chiropractic PC

7 E Woodland Ave., Springfield, PA 19064
610-544-6336 fax 610-544-7059

Motor Vehicle Accident Intake Form

Today's Date:

Name: | Date of Birth: / /

Address:

Insurance Company: Claim Number:

Insurance Adjuster Name/Phone Number:

Accident Information:

Date/Time of Accident/Injury: / / at ____:____ AM PM State: PA Other: _____

You were: *Driver* *Front Passenger* *Rear passenger* Your vehicle's speed: _____ mph

Vehicle type: *Car* *Van/minivan* *Truck* *SUV* *Motorcycle* *Other:* _____

Position of vehicle: *Stopped at intersection* *Stopped in traffic* *Making a right turn* *Making a left turn* *Parking*

Proceeding along *Accelerating* *Slowing down* *Other:* _____

Visibility was: *Poor* *Fair* *Good* Road conditions were: *Snowy/Icy* *Wet* *Clean and Dry*

What happened? *You hit other vehicle* *Other vehicle hit you* *You hit ...(object)* _____

Impact to your car: *Front* *Left front* *Right front* *Rear-end* *Left rear* *Right rear* *Left side door(s)* *Right side door(s)*

Did you see the accident coming? *Yes* *No* Were you braced for the impact? *Yes* *No*

Were you wearing a seat belt? *Yes* *No* Position of headrest: *Even with top of head* *Middle of neck*

Head position at time of impact: *facing forward* *looking left* *looking right*

Did airbags deploy? *Yes* *No* Did your body strike the inside of the vehicle? *Yes* *No*

Did you lose consciousness? *Yes* *No* Did police come to the scene of the accident? *Yes* *No*

Additional comments: _____

After the Accident:

Where did you go following the accident? *Home* *Work* *ER* *Family doctor*

How did you get there? *Self* *Someone else* *Ambulance* If ER, were x-rays taken? *Yes* *No*

Circle any symptoms you had after the accident:

Headache *Back/neck pain* *Back/neck stiffness* *Dizziness* *Nausea* *Confusion* *Nervousness* *Diarrhea* *Depression* *Fatigue*

Loss of taste/smell *Ringing in ears* *Fainting* *Tension* *Chest pain* *Shortness of breath* *Sleeping problems* *Toe numbness*

Other: _____

Health History

Hospitalizations:

Surgeries:

Prior accidents/injuries:

Ongoing illness:

Allergies:

Current Medications:

Nutritional Supplements :

Prior Chiropractic Care? *Yes* *No* If yes, where?

(Females only) Pregnant? *Yes* *No*

Have a pacemaker/defibrillator? *Yes* *No*

Date of last x-ray or MRI: / /

Comments:

Springfield Family Chiropractic PC Patient Name: _____

SYMPTOM FORM Date: _____

1st Symptom:

Location: (Circle ONE)
Head
Neck
Upper Back
Mid Back
Low Back
Buttocks
Tailbone
Extremity:
Arm/Hand
Leg/Foot
Other_____

Which side?:
Left Side
Right Side
Both Sides

Frequency:
Constant
Frequent
Intermittent
Occasional

Type of Pain: (Circle all that apply)
Aching Dull Sharp Stabbing Burning

Other accompanying symptoms:
Stiffness Weakness Numbness/Tingling

What aggravates your pain?
Bending Twisting Standing Sitting Other_____

What helps your pain?
Rest Heat Ice OTC Pain Reliever Other_____

Pain Level: (1=mild, 10=severe)
1 2 3 4 5 6 7 8 9 10

2nd Symptom:

Location: (Circle ONE)
Head
Neck
Upper Back
Mid Back
Low Back
Buttocks
Tailbone
Extremity:
Arm/Hand
Leg/Foot
Other_____

Which side?:
Left Side
Right Side
Both Sides

Frequency:
Constant
Frequent
Intermittent
Occasional

Type of Pain: (Circle all that apply)
Aching Dull Sharp Stabbing Burning

Other accompanying symptoms:
Stiffness Weakness Numbness/Tingling

What aggravates your pain?
Bending Twisting Standing Sitting Other_____

What helps your pain?
Rest Heat Ice OTC Pain Reliever Other_____

Pain Level: (1=mild, 10=severe)
1 2 3 4 5 6 7 8 9 10

3rd Symptom:

Location: (Circle ONE)
Head
Neck
Upper Back
Mid Back
Low Back
Buttocks
Tailbone
Extremity:
Arm/Hand
Leg/Foot
Other_____

Which side?:
Left Side
Right Side
Both Sides

Frequency:
Constant
Frequent
Intermittent
Occasional

Type of Pain: (Circle all that apply)
Aching Dull Sharp Stabbing Burning

Other accompanying symptoms:
Stiffness Weakness Numbness/Tingling

What aggravates your pain?
Bending Twisting Standing Sitting Other_____

What helps your pain?
Rest Heat Ice OTC Pain Reliever Other_____

Pain Level: (1=mild, 10=severe)
1 2 3 4 5 6 7 8 9 10

Springfield Family Chiropractic PC

Name:

Date:

ACTIVITIES OF DAILY LIVING ASSESSMENT

	1-Causes some pain	2-Causes significant pain	3-Cannot do because of pain	N/A
Self-care and Personal Hygiene				
Bathing				
Brushing teeth				
Putting on shoes				
Doing laundry				
Grooming hair				
Making bed				
Putting on pants				
Doing dishes				
Washing face				
Putting on shirt				
Cooking				
Taking out trash				
Sitting on toilet				
Physical Activities				
Standing				
Walking				
Reaching				
Bending right				
Twisting right				
Sitting				
Squatting				
Bending				
Bending left				

	1-Causes some pain	2-Causes significant pain	3-Cannot do because of pain	N/A
Physical Activities (cont.)				
Twisting left				
Reclining				
Bending back				
Kneeling				
Looking left				
Looking right				
Functional Activities				
Carrying small object				
Lifting weight off table				
Push/pull standing				
Carrying large object				
Climbing stairs/incline				
Exercising upper body				
Exercising lower body				
Carrying purse/case				
Lifting object off floor				
Push/pull seated				
Social/Recreational Activities				
Jogging				
Biking				
Swimming				
Dancing				
Golfing				

	1-Causes some pain	2-Causes significant pain	3-Cannot do because of pain	N/A
Social/Recreational Activities (Cont.)				
Bowling				
Hunting				
Fishing				
Gardening				
Basketball				
Soccer				
Hockey				
Competitive sports				
Travel				
Driving in car				
Riding as passenger				
Entering/exiting vehicle				
Driving for long periods				
Riding for long periods				
Other Activities				
Concentrating				
Studying				
Listening				
Reading				
Writing				
Using computer				
Sleeping				

Springfield Family Chiropractic PC	Name:
	Date:

Oswestry Low-Back Pain Disability Questionnaire

Choose ONE item in each section.

1-Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

2-Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally, without any extra pain.
- ☐ I can look after myself, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow/careful.
- ☐ I need some help, but can manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

3-Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage them if they are conveniently placed (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything.

4-Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

5-Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than an hour.
- ☐ Pain prevents me from sitting for more than 30 minutes
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

6-Standing

- ☐ I can stand as long as I like without extra pain.
- ☐ I can stand as long as I like, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than an hour.
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

7-Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is compeletely disturbed (5-7 hours sleepless).

8-N/A

9-Social Life

- ☐ My social life is normal and does not cause extra pain.
- ☐ My social life is normal but causes some pain.
- ☐ My social life is limited somewhat by pain.
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I do not have a social life because of pain.

10-Traveling

- ☐ I can travel without pain.
- ☐ I can travel as long as I want, but it causes some pain.
- ☐ I can travel for more than 2 hours, but it causes moderate pain.
- ☐ Pain restricts me to travel of less than an hour.
- ☐ Pain restricts me to short, necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling, except to receive treatment.

Springfield Family Chiropractic PC	Name:
	Date:

Neck Disability Index

Choose ONE item in each section.

1-Pain Intensity	6-Concentration
☐ I have no pain at the moment.	☐ I can concentrate fully when I want to, with no difficulty.
☐ The pain is mild at the moment.	☐ I can concentrate fully when I want to, with slight difficulty.
☐ The pain comes and goes and is moderate	☐ I have a mild degree of difficulty in concentrating when I want to.
☐ The pain is moderate and does not vary much.	☐ I have a moderate degree of difficulty concentrating when I want to.
☐ The pain is very severe, but comes and goes.	☐ I have a great deal of difficulty in concentrating when I want to.
☐ The pain is severe and does not vary much.	☐ I cannot concentrate at all.
2-Personal Care (washing, dressing, etc.)	**7-Work**
☐ I can look after myself normally, without any extra pain.	☐ I can do as much work as I want to.
☐ I can look after myself, but it causes extra pain.	☐ I can only do my usual work, but no more.
☐ It is painful to look after myself, and I am slow/careful.	☐ I can do most of my usual work, but no more.
☐ I need some help, but can manage most of my personal care.	☐ I cannot do my usual work.
☐ I need help every day in most aspects of self-care.	☐ I can hardly do any work at all.
☐ I do not get dressed, wash with difficulty, and stay in bed.	☐ I cannot do any work at all.
3-Lifting	**8-Driving**
☐ I can lift heavy weights without extra pain.	☐ I can drive my car without neck pain.
☐ I can lift heavy weights, but it gives me extra pain.	☐ I can drive my car with slight neck pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage them if they are conveniently placed (e.g., on a table).	☐ I can drive my car as long as I want, with moderate neck pain.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.	☐ I cannot drive my car as long as I want, due to moderate neck pain.
☐ I can only lift very light weights.	☐ I can hardly drive my car at all, due to severe neck pain.
☐ I cannot lift or carry anything.	☐ I cannot drive my car at all.
4-Reading	**9-Sleeping**
☐ I can read as much as I want to with no neck pain.	☐ I have no trouble sleeping.
☐ I can read as much as I want to with slight neck pain.	☐ My sleep is slightly disturbed (less than 1 hour sleepless).
☐ I can read as much as I want to with moderate neck pain.	☐ My sleep is mildly disturbed (1-2 hours sleepless).
☐ I cannot read as much as I want because of moderate neck pain.	☐ My sleep is moderately disturbed (2-3 hours sleepless).
☐ I cannot read as much as I want because of severe neck pain.	☐ My sleep is greatly disturbed (3-5 hours sleepless).
☐ I can read at all because of the pain.	☐ My sleep is compeletely disturbed (5-7 hours sleepless).
5-Headache	**10-Recreation**
☐ I have no headaches at all.	☐ I am able to engage in all recreational activities with no pain in my neck at all.
☐ I have slight headaches which come infrequently.	☐ I am able to engage in all recreational activities with some pain in my neck.
☐ I have moderate headaches which come infrequently.	☐ I am able to engage in most, but not all, recreational activities because of pain in my neck.
☐ I have moderate headaches which come frequently.	☐ I am able to engage in only a few of my usual recreational activities, due to the pain in my neck.
☐ I have severe headaches which come frequently.	☐ I can hardly participate in any recreational activities because of pain in my neck.
☐ I have headaches almost all the time.	☐ I cannot do any recreational activities at all.

Springfield Family Chiropractic, P.C.
Dr. Gary S. Miller
7 E. Woodland Avenue
Springfield, PA 19064

Patient Name: _____

Authorization for Assignment and Records Release

I authorize Springfield Family Chiropractic PC to:

1. Release medical records to an insurance company, attorney or adjuster in order to process a claim for payment of charges incurred.
2. Be paid directly for their services by the covering insurance company, attorney, or adjuster.

Payment of Non-Covered Services

I agree to be personally responsible for payment, in the event that my insurance company does not cover the services by Springfield Family Chiropractic, P.C.

Terms of Acceptance

When a patient comes to our office for chiropractic care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. Chiropractic has only one goal – to remove vertebral subluxations.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of neural impulses.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will notify you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Privacy Notice

I acknowledge that I have received the *Notice of Privacy Practices*.

Minor Child Consent (parent or guardian signs if patient is under 18) Signature: _____

I give my consent for my minor child (or ward) to be treated by Springfield Family Chiropractic, P.C. This includes chiropractic adjustments and adjunctive therapies that are recommended.

By signing below, I indicate that I have read and fully understand the above statements.

Signature: _____ Date: ____/____/_____