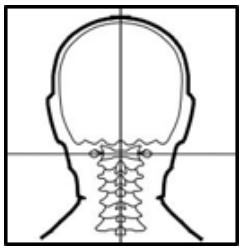


Atlas Spinal Care, P.C.

WORK ACCIDENT INTAKE

16500 SE 15th Street, Suite 160
(360) 718 - 7944 Vancouver, WA 98683 Fax (360) 718 - 7931

Patient Information

Patient Name: _____ If a Minor, Responsible Party:_____

Address: _____City_____ State_____Zip_____

Birth Date ___/___/___ Age ____ Male ___ Female ___ Social Sec. # ____/____/_____

Occupation _____ Employer _____

Marital Status: _____ # of children _____ Email: _____

Home # _____ Work # _____ Cell #_____ Best way to contact: _____

Emergency Contact: Name:_____ Relationship: _____

Home #_____ Cell #_____

Billing Information

Date of accident ____/____/____ Time of Day _____ am/pm

Type of work being done at time of accident:_____

Where did the accident occur? _____ City? _____ State?_____

Has a claim been filed? __Yes __No If yes, claim #:_____ State Claim Filed: _____

Name of Adjuster: _____

Job Description

In terms of an 8 hour workday, circle number of hours per activity.

Sit: 1 2 3 4 5 6 7 8 hours Stand: 1 2 3 4 5 6 7 8 hours Walk: 1 2 3 4 5 6 7 8 hours

On the job, I perform the following activities: __ Bend/stoop squat __ Balancing __ Crouch/Kneel

__ Climb/reach above shoulder level __Pulling

The above is done: __Occasionally __ Frequently __ Continuously

On the job, I lift: __ less than 10 lbs __ 11-30 lbs __ 31-50 lbs __ over 50 lbs __ No lifting at all

Health History

What other treatments have you had for this condition?

__Chiropractic __ Physical Therapy __Neurologist __ Medication __ Surgery __ Orthopedic

Other:_____

Name of Doctor(s) who have treated you for this condition?_____

Date of last: Physical Exam: _____ Spinal X-ray: _____ MRI: _____ CT Scan: _____

List any allergies you currently have (food, medication, etc): _____

_____

List any medications you are currently taking: _____

_____

List any vitamins/herbs/minerals you are currently taking: _____

_____

Previous surgeries & dates: _____

Broken bones & dates: _____

Falls/Injuries & dates: _____

Female Patients Are you pregnant? ___Yes ___ No Beginning of last menstrual cycle: _____

Circle any of the following conditions you have had or are currently experiencing:

Earache	Epilepsy/Seizures	Anxiety/Depression	Arm/Shoulder Pain	Arthritis
Asthma	Bladder Problems	Cancer	Chronic Fatigue	Deafness
Diabetes-Type 1/Type 2	Digestion Problems	Ear Ringing	High Blood Pressure	Headaches
Heart Disease	Hepatitis	Herniated Disc	Insomnia	Kidney Problems
Leg Pain	Neck Pain	Mid-Back Pain	Migraines	
Low Back Pain	Osteoporosis	Poor Circulation	Prostate Issues	
Rheumatoid Arthritis	Scoliosis	Shingles	Sinus Infection	
Stroke	Thyroid Issues	TMJ	Vertigo/Dizziness	

Other: _____

Stressors:

Smoking	Packs/Day _____
Alcohol	Drink/Week _____
Caffeine	Cups/Day _____
High Stress Level	Reason _____

Exercise:

___ None __ Moderate

___ Heavy ___# of days/week

Please bring in copies of ALL reports related to the accident

Accident Symptoms & Complaints

Describe how accident occurred: _____

_____

What is your major symptom/problem?_____

Have you had this problem before? _____ Has the accident made the symptoms worse? _____

Is this problem getting progressively worse? _____

Are your complaints similar to the result of previous accident(s)? Yes / No

Please provide details of previous accident(s) _____

Did you experience any of the following symptoms after the accident: **(circle what applies)**

Loss of consciousness / Dizziness / Confusion / Tingling in arms or legs / Disorientation
Numbness in arms or legs / Neck pain / Neck stiffness / Low back pain / Low back stiffness

Blurred vision / Warm spots in your body / Cold spots in your body / Headaches

Have you had difficulty with any of the following daily activities since the accident?

Sleeping / Sitting / Walking / Eating / Reading / Concentrating / Bowel movements

What makes your condition better? _____ What makes your condition worse? _____

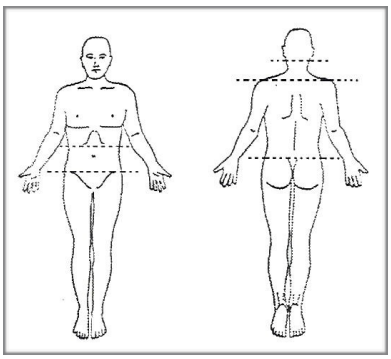
Do your accident symptoms interfere with: Work ___ Sleep ___ Daily Routine ___ Recreation ___

Activities/Movements that are painful to perform: Sitting __ Standing __ Walking __ Bending ___

Lying Down ___ Driving ____ Reading ___ Other:_____

Have you returned to work since accident? Y / N Date returned: _____ Light / Regular Duty — Full / Part Time

Circle the severity of your pain (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)



Please note on the diagrams any areas of contusions, bruising, cuts, lacerations or scrapes you received as a result of you accident

The statements made on this form are accurate to the best of my knowledge and I agree to be examined at Atlas Spinal Care for treatment of my symptoms.

Patient Signature _____ **Date** _____

Date _____

FUNCTIONAL LOSS PATIENT QUESTIONNAIRE

	Left	Right
Neck movement limited	____	____
Shoulder movement limited	____	____
Elbow movement limited	____	____
Wrist movement limited	____	____
Hand movement limited	____	____
Finger movement limited	____	____
Upper back movement limited	____	____
Lower back movement limited	____	____
Hip movement limited	____	____
Numb upper leg	____	____
Knee movement limited	____	____
Numb lower leg	____	____
Ankle movement limited	____	____
Numb foot	____	____
Foot movement limited	____	____

	Left	Right
Numb face	____	____
Numb neck	____	____
Numb upper arm	____	____
Numb lower arm	____	____
Numb hand	____	____
Numb upper back	____	____
Numb lower back	____	____
Numb hip	____	____

	Moderate	Severe	Mild
Neck weakness	_____	_____	_____
Shoulder weakness	_____	_____	_____
Upper arm weakness	_____	_____	_____
Lower arm weakness	_____	_____	_____
Wrist/Hand grip weakness	_____	_____	_____
Upper back weakness	_____	_____	_____
Lower back weakness	_____	_____	_____
Hip weakness	_____	_____	_____
Upper leg weakness	_____	_____	_____
Lower leg weakness	_____	_____	_____
Ankle/foot weakness	_____	_____	_____

Circle the following activities that are difficult:

Walking / Running / Standing / Sitting / Bending / Kneeling / Crawling / Stooping / Lifting / Twisting

Pushing / Pulling / Tying Shoe Laces / Grooming finger nails / Grooming toe nails / Climbing up stairs

Climbing down stairs / Putting on pants / Putting on shoes/socks / Buttoning shirts/pants / Lifting one arm

Lifting both arms / Hand coordination / Balancing while standing / Sleeping / Dizziness / Sleeping-pain in neck

Sleeping-pain in arm / Sleeping-pain in upper back / Sleeping-pain in lower back / Sleeping-pain in hip

Sleeping-pain in upper leg / Sleeping-pain in lower leg / Sleeping-pain in foot / Fatigue / Memory / Speaking

Hearing / Headaches / Migraines / Forgetful of numbers / Forgetful of tasks / Forgetful of names /

Breathing / Bowel movements / Sexual desire / Sexual ability

In your words, please describe how your life has been affected since the accident. Please be very descriptive in your explanation and use complete sentences:

Social: Dancing, sports, gardening, hobbies, family activities:

Work: Changes in performing your job, changes in jobs:

Atlas Spinal Care, P.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

Washington State Law requires that chiropractic patients be provided with the following information prior to being treated.

Chiropractic examination and therapeutic procedures (including spinal adjustments, muscle therapy, exercise and traction) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare.

Alternatives to chiropractic care include but are not limited to medical treatment, physical therapy, acupuncture and massage. If you have any questions, please feel free to discuss them with the doctor.

I have read, or have had read to me, the above consent. By signing below I agree to the above and allow the doctor or associates, affiliated with *Atlas Spinal Care* to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name (Printed) _____

Patient Signature _____ Date: _____

(Or Patient Representative) (Indicate relationship if signing for patient)

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and/or associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Patient Signature _____ Date: _____

Atlas Spinal Care, P.C.

OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations can cause severe scheduling disruptions which can interfere with the quality of care you and other patients receive.

Please do not wear strong perfumes/colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 24 hours of your scheduled appointment.

Children are welcome in the clinic. You are responsible for your children's actions at all times. Our staff will assist you with your well-behaved children.

We may schedule you for multiple appointments. This will help insure convenient appointment times for you as well as provide you with the highest level of care possible. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly. Please notify your doctor of **any** changes in your health status regardless of the significance.

FINANCIAL POLICIES

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card. There will be a 3% service fee for all payments made on a credit or debit card over $1,000.

Payment is expected at the time of your visit. We will bill your primary insurance company for Initial Intensive Care as a courtesy to you. The patient is always responsible for the payment of their care. An insurance contract is between the patient and their insurance company.

Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.

Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of $35 per occurrence.

We do offer a *time of service discount* when services are paid in full at the time of the visit. This discounted amount will be passed on to your insurance company.

In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service* discount. Please ask us if you have any questions.

Feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care

Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company and you will be responsible for your account regardless of insurance

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or guardian: _____ Date: ____/____/____