

# Advanced Care Chiropractic REGISTRATION

Date \_\_\_\_\_

Patient \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name      First Name      Middle Initial

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  # of children \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ Religion (optional) \_\_\_\_\_

**Condition Related to:**  Auto Accident  Work-related Injury  Other Injury  Illness  Unknown

<b>EMPLOYER</b>	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
<b>SPOUSE</b>	Name _____ <small style="margin-left: 100px;">Last Name</small> <small style="margin-left: 100px;">First Name</small> <small style="margin-left: 100px;">Middle Initial</small> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____
<b>INSURANCE INFORMATION</b>	<p style="text-align: center;"><b>Health Insurance (if you have card, please give it to receptionist to make copy)</b></p> Insurance _____ Insured's Name _____ Group # _____ ID# _____
<b>MEDICAL AND LEGAL INFORMATION</b>	Family Physician _____ Phone _____ Attorney (if auto or work-related) _____ Phone _____ Known Medical Problems _____ _____ Person to contact in emergency (Name & Phone #) _____ _____
<b>PATIENT AGREEMENT</b>	<p><b>ASSIGNMENT AND RELEASE</b></p> <p>I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Advanced Care Chiropractic all medical benefits otherwise payable for services. I understand that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office. I authorize the use of this signature on all my insurance submissions and to obtain records.</p> <p style="text-align: center;">_____ Date _____                  Signature of Insured/Guardian</p>

How did you learn of our practice?  Yellow Pages  Personal referral  Drive by/Sign  Other

If you were referred, whom may we thank? \_\_\_\_\_

**FINANCIAL POLICY**

Payment is requested for all office services at the time rendered and may be paid by cash or check. Payment on the day of service is eligible for a cash discount. If you have insurance that pays for chiropractic, we will be glad to bill for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements, please talk to the office manager.

# Advanced Care Chiropractic

**Brian L. Vroom, DC, DAAPM**

**Michelle Waggoner, DC**

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## CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) 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, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature \_\_\_\_\_

Date \_\_\_\_\_

<b>STOP HERE</b>
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Portion Below Used If Additional Information Requested & Received

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Date and time of accident \_\_\_\_\_

Location of accident (city, state, street) \_\_\_\_\_

Road Condition wet dry snow/ice other \_\_\_\_\_

Were police notified of the accident? Y N Was a report filed? Y N Unknown

Collision involved: one vehicle 2 vehicles 3 or more vehicles pedestrian other \_\_\_\_\_

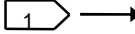


Did you go to the hospital afterwards? Y N Name \_\_\_\_\_ How did you get there? \_\_\_\_\_

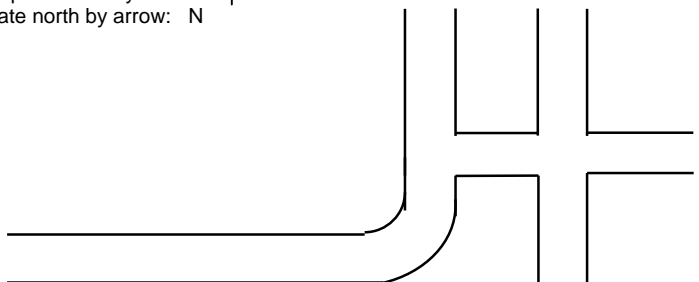
Were you examined by a doctor? Y N Were X-rays taken? Y N Body parts x-rayed \_\_\_\_\_

What did the doctor say was wrong? \_\_\_\_\_

Treatment given \_\_\_\_\_ Medications given \_\_\_\_\_

**INDICATE ON THIS DRAWING WHAT HAPPENED**  
 SKETCH IN THE SCENE OF YOUR ACCIDENT, WRITING IN STREET OR HIGHWAY NAMES

1. Number vehicles (1 for yours) and show direction of travel by an arrow: 
2. Use solid line to show path before accident \_\_\_\_ dotted line after -----
3. Show distance and direction to landmarks; identify landmarks by name/number.
4. Show pedestrian by 
5. Indicate north by arrow: N 



1. Driver of car \_\_\_\_\_ Where were you seated? Driver Front passenger Rear left Rear right

2. Other occupants in car and their injuries \_\_\_\_\_

3. You were struck from: Behind Front Left side Right side Other \_\_\_\_\_

4. Were you aware of the collision prior to impact? Y N Did you brace for impact? Y N

5. How far is the headrest (or seatback) from your head? less than 3" 3 to 6" more than 6"

6. Were you wearing a: seatbelt shoulder harness none

7. Did the airbag deploy? Y N

8. Year/make/model of the car you were in \_\_\_\_\_ Est. cost of damage \_\_\_\_\_ Was it drivable? Y N

9. What car parts were damaged?(e.g. seatback, window, rearview mirror, etc.) \_\_\_\_\_

10. Was your car moving at the time of collision? Y N If yes, how fast? \_\_\_\_\_ Mph. Were you braking? Y N

If no, was the driver's foot on the brake? Y N

11. Did your body strike anything in the car? \_\_\_\_\_

12. Was your head: Pointed straight forward Turned to the left Turned to the right

13. Year/make/model of other car \_\_\_\_\_ Damage: minor mod severe Was it drivable? Y N

14. Was the other car moving at the time of collision? Y N If yes, how fast? \_\_\_\_\_ Mph.

15. If moving, was the other vehicle slowing down gaining speed traveling at a steady speed

16. Describe how the accident happened: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

17. Describe where you felt pain or unusual feelings: (location, type, severity)

- a) During the accident \_\_\_\_\_  
\_\_\_\_\_
- b) Immediately after the accident \_\_\_\_\_  
\_\_\_\_\_
- c) Later that day/night: (and up to now) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Did you lose consciousness (black-out)? YN If yes, for how long? \_\_\_\_\_ If no, were you dazed/confused? Y N

19. Did you experience a flash of light or explosion in your head? Y N

20. Did you receive any injuries/bruises/cuts from the seatbelt or airbag? Y N

21. Did you receive bleeding cuts? Y N Did you receive bruises? Y N Where? \_\_\_\_\_

22. Check the symptoms you have noticed since the accident:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Ringing/buzzing in ears   | <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Diarrhea/constipation |
| <input type="checkbox"/> Neck pain/stiffness     | <input type="checkbox"/> Loss of smell/taste       | <input type="checkbox"/> Numbness in toes       | <input type="checkbox"/> Stomach upset/pain    |
| <input type="checkbox"/> Mid back pain           | <input type="checkbox"/> Loss of memory            | <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Blood in urine        |
| <input type="checkbox"/> Jaw pain                | <input type="checkbox"/> Tension                   | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Chest pain            |
| <input type="checkbox"/> Shoulder/arm/wrist pain | <input type="checkbox"/> Difficulty concentrating  | <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Hip/leg/knee/ankle pain | <input type="checkbox"/> Dizziness/loss of balance | <input type="checkbox"/> Restlessness           | <input type="checkbox"/> Nervousness/anxiety   |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Forgetfulness             | <input type="checkbox"/> Head feels too heavy   | <input type="checkbox"/> Other _____           |

23. Since this injury, are your symptoms Improving? Getting worse? Staying about the same?

24. When are your symptoms worst? Morning Afternoon Evening Night

25. How did you feel before the accident? \_\_\_\_\_

26. Ongoing conditions/complaints experienced before accident \_\_\_\_\_  
\_\_\_\_\_

27. Are your work activities restricted because of your injuries? YN Last date worked \_\_\_\_\_

28. Have you lost time from work as a result of this accident? YN Explain \_\_\_\_\_

29. Describe your work duties \_\_\_\_\_  
\_\_\_\_\_

30. Have you injured this area of your body before? Y N If yes, explain \_\_\_\_\_

31. If you have been in other auto or work accidents, list year and describe briefly:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

32. Have you seen any other doctors as a result of this accident? YN If yes, by whom? \_\_\_\_\_

33. What was the treatment (if any)? \_\_\_\_\_ Did it help? Y N

34. Are you pregnant? YN Date of last menstrual period \_\_\_\_\_

35. Have you consulted an attorney? Y N Name \_\_\_\_\_

**PATIENT'S SIGNATURE** \_\_\_\_\_

**PARENT/GUARDIAN'S SIGNATURE** (if under 18) \_\_\_\_\_