UPSTATE INJURY CENTER

(864) 552-1142
2520 Wade Hampton Blvd
Suite B
Greenville, SC 29615

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name | Your Social Security Number | Birth Date (MM/DD/YYYY) | Age

Your First Name | Your Middle Name (or Initial) | Gender ○ Male ○ Female | Race

Address | Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated | Ethnicity

City | State/Province | ZIP/Postal Code | Preferred Language

Home Phone | Cell Phone | Spouse's Name

Email Address | Child's Name and Ago

Emergency Contact | Emergency Contact's Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer | Work Phone

Address | May we contact you at work? ○ Yes ○ No

City | State/Province | ZIP/Postal Code | Preferred method of Contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Emal

Primary care Provider's Name

Insurance Carrier | Policy Number

Insured's Last Name | Birth Date (MM/DD/YYYY) | Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name | Insured's Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

CAD Injury History Form

General information:

Patient' name: _____
Today's date: _____
Date of injury: _____
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____ Years _____
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: _____
☐ Unemployed
Currently: _____
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal Injuries (date, TX, awards, residuals):

Sports or other injuries to head, neck, or back:

Past medical history (cont'd)

Any prior HX of current complaints:
1. _____
2. _____
3. _____
Prior TX by DC for these:
1. _____
2. _____
3. _____

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

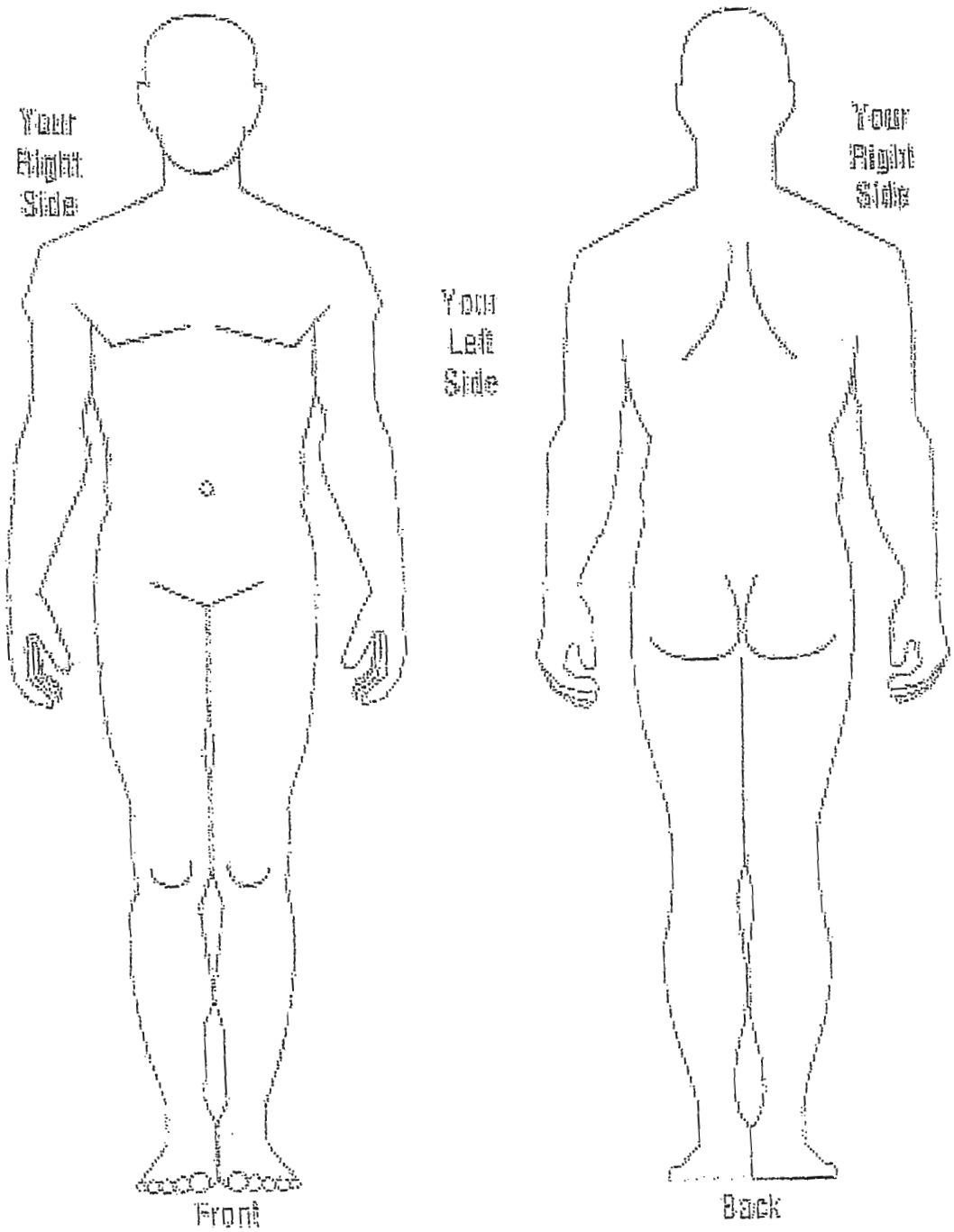
Injury history. General:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other _____
Vehicle driven by: _____
Your vehicle (year, make, model): _____
Your estimated speed at moment of crash: _____
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): _____
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean
Other _____
Head position: ☐ Forward ☐ Left ___°
☐ Right ___° ☐ Up ___° ☐ Down ___°

Patient Name:_____ Date:_____

Please make the location of your pain using the symbols below:

///// : Ache xxxx : Pain oooo : Tingling ---- : Numb



Injury history. General: (cont'd)

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No
Crash description: _____

Crash diagram:

Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe _____
Did vehicle strike any objects after crash?
If yes, describe _____
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long? _____
Estimated property damage to your vehicle:
$ _____
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Paresthesia(s)
If yes, where? _____
☐ Extremity pain. If yes, where? _____
☐ Back pain
When did SX first appear? ☐ Immediately
(describe which SX) _____ hr afterward
Where did you go after crash? ☐ Home ☐ Work ☐ Hospital:
Mode of transportation _____
Pvt. doctor: _____

Emergency department:

Radiographs: ☐ Yes ☐ No
Body parts imaged _____
Results _____
Lab work ☐ Yes ☐ No _____
☐ Cervical collar ☐ Ice
Medications: _____
Other: _____
Follow-up instructions: ☐ None _____

Treatment history:

1. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

2. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

Treatment history: (cont'd)

3. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

4. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

5. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

6. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? ☐ Yes ☐ No
Notes: _____

Original chief complaints (if injury was not recent):

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

Current chief complaints:

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

Self assessment as of today: % improved (list for separate areas)

_____
_____
_____

Request records:

☐ 1. Request radiographs from: _____
_____

☐ 2. Request records from: _____
_____

☐ 3. Request copy of police report.

Referral:

☐ For: _____
☐ To: _____

Tests to order:

☐ Radiographs: _____
☐ Tomograms: _____
☐ CT: _____
Area(s): _____
☐ MRI: _____
Area(s): _____
☐ MRA: _____
Area(s): _____
☐ Scintigraphy/SPECT: _____
Area(s): _____
☐ Videofluoroscopy: _____
Area(s): _____
☐ EMG/NCV: _____
Root level/nerve(s): _____
☐ SEP: _____
Root level/nerve(s): _____
☐ Other electrodiagnostic test(s): _____
☐ Ultrasound: _____
Area(s): _____

Action taken on this visit:

☐ Exam/TX: _____
_____
☐ Place on disability: _____
☐ Work restriction: _____
☐ Referral: _____
☐ Brace/collar: _____
☐ Home traction device: _____
☐ NEXERCICER: _____
☐ Supplements: _____
☐ Other: _____

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: _____

Address: _____

FINANCIAL AGREEMENT PERSONAL INJURY

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your injury. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Party Responsibility
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of *your* automobile insurance policy to cover the treatment charges incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
3rd Party: If another vehicle has caused the accident, we will first bill your automobile Med Pay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault. If we rely solely on a 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement. ***By signing this form, you are agreeing to pay your balance in full within 3 days of receiving your settlement.*** x_____ (Patient's Initials)

Attorney Liens
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____
Patient's Signature Date

_____ _____
Patient's Name Printed Witness' Signature