|  |  |
| --- | --- |
| ***A picture containing food  Description automatically generated*** | Tel: (615) 448-6446  313 Bluebird Drive Suite B  Goodlettsville, TN 37072  www.promassagenow.com |

**CONFIDENTIAL PATIENT INFORMATION**

**Personal Information**

|  |  |
| --- | --- |
| **Full name: Date:** | |
| **Address:**  Street City State Zip | |
| **Home phone:** | **Work phone:** |
| **Cell phone:** | **Email address:** |
| **Best time/place to contact you: SS#:** | |
| **Date of birth: Age:** | **No. of children:** |
| **Pregnant? Yes** □ **No** □ | **Height: Weight:** |
| **Marital status: M S W D** | **Spouse/guardian name:** |
| **Occupation:** | **Employer’s name & address:** |
| **Name of person responsible for account:** |  |
| **Emergency Contact Name: Relationship:** | |
| **Phone Number:** | |

**MY CAR INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Adjuster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Phone  (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims fax (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To send claims to

**OTHER PARTIES CAR INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Adjuster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Phone  (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims fax (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1 of 4 – PMC Intake Revised 4-17-19

**General Health History** *Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!*

Have you had any surgery? (Please include all surgery)

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Doctor |
| 2. Type: | When? | Doctor |
| 3. Type: | When? | Doctor |
| 4. Type: | When? | Doctor |

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Hospitalized? Yes □ No □ |
| 2. Type: | When? | Hospitalized? Yes □ No □ |
| 3. Type: | When? | Hospitalized? Yes □ No □ |

Have you ever had x-rays taken?

|  |  |  |
| --- | --- | --- |
| Area of body: | When? | Where? |

***Current Medicines and Supplements***

**List Type of Medications and/or supplements you are taking:**

 Anxiety  Muscle Relaxers  Pain Killers  Insulin  Birth control  Cardiovascular

 Allergy  Seizure  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**List any Allergies**:

 Animals  Aspirin  Bees  Chocolate  Dairy  Dust  Eggs  Latex  Molds  Nuts

 Penicillin  Rubber  Ragweed/Pollen  Seasonal Allergies  Shellfish  Soaps  Wheat

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Health History**

Please mark the following conditions you may have had or have now

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ Alcoholism | □ Allergies | □ Anemia | □ Arteriosclerosis | □ Arthritis | □ Asthma |
| □ Back Pain | □ Cancer | □ Cold Sores | □ Constipation | □ Convulsions | □ Depression |
| □ Diabetes | □ Diarrhea | □ Eczema | □ Emphysema | □ Epilepsy | □ Fibromyalgia |
| □ Gout | □ Headaches | □ Heart Attack | □ Heart Disease | □ High Blood Pressure | □ HIV (Aids) |
| □ Irregular Periods | □ Low Blood Sugar | □ Malaria | □ Measles | □ Menstrual Cramps | □ Migraines |
| □ Miscarriage | □Multiple Sclerosis | □Mumps | □ Neck Pain | □ Nervousness | □ Neuritis |
| □ Pleurisy | □ Pneumonia | □ Polio | □ Rheumatic Fever | □ Ringing in ears | □Sinus problems |
| □ Stroke | □ Thyroid Problems | □Tuberculosis | □ Ulcers | □ Venereal Disease | □ Whooping Cough |

Other (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you smoke? □ Yes □ No Number of packs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? □ Yes □ No Number of Drinks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2 of 4 – PMC Intake Revised 4-17-19

**Informed Consent for Chiropractic Care/Massage Therapy**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic X-Rays, on me (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Pro Massage & Chiropractic or any doctor, who now or in the future, that works as a relief doctor. I also consent to modalities being done by licensed CTA’s and massage therapy being done by licensed LMT’s.

I understand I may receive massage therapy as part of my treatment plan. In regards to massage therapy I understand I have the following rights and responsibilities:

• I have the right to control the amount of pressure applied.

• I have the right to my comfort in the area of temperature, music, lighting, table positioning and draping technique for my highest comfort level.

• I have the right to talk or not to talk, share or not share about my internal experiences.

• I have the right to be treated with respect and without judgment: physically, emotionally, and spiritually.

• I have the right to experience safety and comfort in respect to areas of the body touched, amount of clothing worn/removed and draping techniques used.

• If the session includes the removal of any clothing, I have the right to dress and undress in privacy.

Client responsibilities:

I will let my practitioner know of all relevant medical issues prior to the start of our session. I agree to let my practitioner know if touch in any area is uncomfortable or needs to be modified for my comfort.

I understand that the touch or manner of communication of the licensed massage therapist is never intended to be sexual in nature. If at any time, I feel the touch, manner or language of the therapist is inappropriate for me, I will immediately inform the practitioner. Inappropriate behavior advances, or language towards the practitioner are grounds for termination of the session resulting in full payment for the session.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions about its content and by signing below, I agree to the above-named procedures. 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 have completed this health form to the best of my knowledge.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OFNOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

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

Patient Signature Date

**THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.**

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

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

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

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

Page 3 of 4 – PMC Intake Revised 4-17-19

|  |  |
| --- | --- |
|  | Tel: (615) 448-6446  313 Bluebird Drive Suite B  Goodlettsville, TN 37072  www.promassagenow.com |

**Irrevocable Lien, Assignment of Benefits and Authorization**

**Insurance Benefits and Attorney**

To Whom It May Concern:

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name of Patient) hereby authorize and direct you, my insurance company, liability insurance adjuster, and/or my attorney to pay directly to: **ProMassage & Chiropractic (“Office”)**  such as may be due and owing to this Office for services rendered to me, both by reason of accident or illness, or any other amounts that are due this office, including but not limited to: interest charges or finance fees and/or collection fees. I authorize and direct you to withhold such sums from any disability benefits, medical payments benefits, no fault benefits, health and accident benefits, workman’s compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office’s services provided and any additional fees or charges that may have accrued. This includes but is not limited to, interest fees and collection fees, including reasonable attorney's fees which may be payable as the result of my account being past due.

In the event any insurance company obligated to make payments to me upon charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand and agree that I remain personally responsible for the total amount due the Office for their services, and any additional fees, including but not limited to interest and collection fees should my account become past due. I further understand that payment due this Office is not contingent upon any settlement, judgment or verdict by which I may recover said fee. I agree to pay all costs of collection of any balance due this Office, including reasonable attorney's fees. Collections cost will increase your bill by 35%,

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney or doctor to facilitate collection under this Assignment, Lien and Authorization I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of amounts due this Office. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. A photocopy of the Assignment, Lien and Authorization shall be considered as effective and valid as the original. I agree not to rescind or revoke any of the terms of this Assignment, Lien and Authorization, and this document shall be valid from the date I signed it until all amounts due the Office are paid in full.

**SIGNATURE**

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Responsible Party if Minor

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 4 of 4 – PMC Intake Revised 4-17-19

**Patient Questionnaire – Auto-Accident**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New Patient □ Yes □ No

**Basic Information about the Accident:**

Date Accident Occurred or Started: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Day when Accident Occurred or Started: \_\_\_:\_\_\_\_\_ AM / PM

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

Automobile you were in: Year \_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Damage to your car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender

Damage Amount Estimate: $\_\_\_\_\_\_\_\_\_\_\_\_\_ : □ Minor □ Major □ Totaled

Other Automobile: Year \_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Damage to other car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender

□ Minor □ Major □ Totaled

Where did the accident happen? Street Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Type of Impact: □ Rear end □ Front □ Side Impact □ Roll Over

Brakes on Impact: □ Locked Tight □ Loosely Applied □ Foot not on brake

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: □ 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your body hit anything inside the car? □ Yes □ No Body Part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1 of 4 – Accident Questionnaire Revised 4-17-19

Taken by ambulance? □ Yes □ No

X-rays taken? □ Yes □ No X-ray areas: □ Neck □ Mid-back □ Low-back □ Other X-rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Given? □ Yes □ No RX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other instruction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Follow-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information Related to the Condition:**

Describe your pain: □ Burning □ Sharp □ Dull □ Ache

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 □ No

When? \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check any of the following symptoms you are now experiencing:

□ Headache □ Dizziness □ Light Bothers Eyes □ Diarrhea □ Head seems too heavy □ Neck Pain

□ Loss of Memory □ Clumsiness □ Feet Cold □ Neck Stiff □ Tingling in arms/hands □ Ears Ring

□ Hands Cold □ Sleeping Problems □ Tingling in legs/feet □ Face Flushed □ Nausea □ Back Pain

□ Numbness in arms/hands □ Buzzing in Ears □ Constipation □ Nervousness □ Numbness in legs/feet □ Loss of Balance

□ Cold Sweats □ Tension □ Shortness of Breath □ Fainting □ Fever □ Fatigue

□ Irritability □ Loss of Smell □ Chest pain/rib pain □ Pain in arms/hands □ Pain in legs/feet □ Jaw pain

□ Loss of strength - arms □ Burning muscle pain □ Loss of strength - legs □ Difficulty swallowing □ Sharp/shooting pain

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced changes to:

□ Eyes (sight) □ Ears (hearing) □ Nose (smell) □ Mouth (taste) □ Bladder

□ Bowels □ Sleep □ Emotion □ Appetite

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you missed work or school due to your injuries? □ Yes □ No

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Page 2 of 4 – Accident Questionnaire Revised 4-17-19

CURRENT SYMPTOMS

**Neck Pain Headache Pain**

Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe

**Upper Back Pain Other Pain**

Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe

**Mid Back Pain Other Pain**

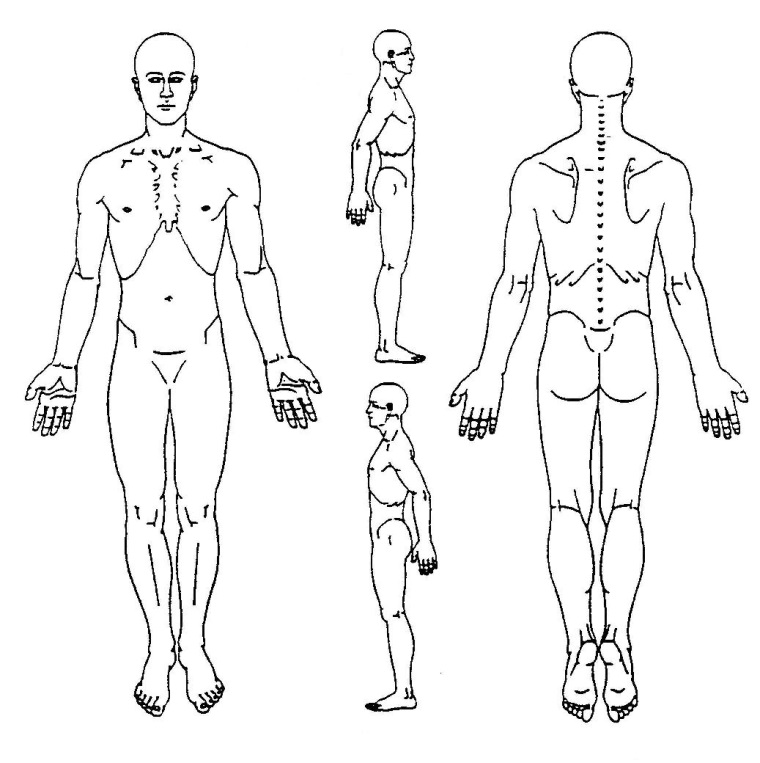
Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe Severity: Mild 1 2 3 4 5 6 7 8 *9* 10 Severe

**Low Back Pain Other Pain**

Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe Severity: Mild 1 2 3 4 5 6 7 8 *9* 10 Severe

Using the letters below, mark the areas on your body where you feel the described sensations, included all affected areas**.**

**A** = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles  **S** = Sharp

****

Page 3 of 4 – Accident Questionnaire Revised 4-17-19



**ATTORNEY ASSISTANCE REQUEST**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have asked ProMassage & Chiropractic for advice and help in retaining a lawyer to represent me. Specifically, I requested assistance in locating a lawyer to represent me as to rights relating to an automobile accident I was involved in on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I fully and completely understand that I have requested and have given an employee of ProMassage & Chiropractic permission to contact an attorney and/or legal investigator on my behalf and have them come and meet me to discuss my legal rights regarding my auto accident. I have also been told that ProMassage & Chiropractic has no business and/or ownership interest in any law firm whatsoever. I know that I am under no obligation to hire any law firm that I may meet with and if I do so, it will be at my full discretion and under no duress and/or pressure from any employee of ProMassage & Chiropractic whatsoever.

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

Patient Signature Date

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

Witness Signature Date

313 Bluebird Drive Suite B, Goodlettsville, TN 37072

615-448-6446