PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

    _____

    _____

    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

    _____

    _____

    _____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritablity	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

_____

_____

_____

23. Other pertinent information: _____

_____

_____

_____

_____ _____

DATE PATIENT'S SIGNATURE

HEALTH
CARE
CENTER

KARL P. BUCH, D.C.
JONI M. BUCH, D.C.
LIZA CAMPBELL, D.C.
3525 Mitchell RD
Bedford, IN 47421
(812) 275-4419

PATIENT INFORMATION

Please print and answer the following questions as accurate and complete as possible.

Today's Date: _____

PERSONAL INFORMATION

Name: _____ Age: _____ Sex: € M F
(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: ____/____/____ SS#____-____-____

Cell Phone:_____ Business/Employer: _____ Work Phone: _____

Email Address:_____ Would you like to receive our E newsletter? Y N

Type of Work Performed: _____ Marital Status: M S W D

Spouse's Name: _____ Children? Sons: _____ Daughters: _____

Emergency Contact: _____ Phone: _____

Who is Your Family Physician? _____ Phone:_____ City: _____

How were you referred to this office? _____ Would you like report sent to Family Physician? Y N

CURRENT HEALTH CONCERNS

Reason for Today's Visit (be specific): _____

When Did This Begin: _____ Experienced Previously? Yes No

Is Condition: Job Related Auto Related Injury Other: _____

Other Doctors Seen For This Problem: _____

Previous Doctor's Opinion/Diagnosis: _____

Were any X-rays/MRIs done: Yes No Where Done: _____

Other or Secondary Complaints: _____

Past Health History

Major Surgeries/Operations: Head Neck/Throat Chest/Heart/Lung
Back Abdominal Other: _____

Previous Fractures or Broken Bones: . . . . . Yes No What: _____
Previous Falls or Accidents: . . . . . Yes No When: _____
Previous Hospitalization: . . . . . Yes No Why: _____
Previous Chiropractic Care: . . . . . Yes No Doctor: _____

Medications Now Taking: . . . Pain Killers/Muscle Relaxants Nerve/Anti-depressants
Blood Pressure Medicine Antibiotics Insulin
Stomach Medicine Heart Vitamins/Supplements
Other: _____

Patient Name: _____ Date of Birth: _____

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as thoroughly as possible.

CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

Allergies	Kidney Problems	Gout	Addictions past/present
Diabetes	Osteo-Arthritis	Chronic Fatigue	Intake or Use:
Cancer	Epilepsy	Lupus	Alcohol
Heart Problems	AIDS or ARC	ALS/MS	Tobacco (chew or smoke)
Stroke	Frequent Illnesses	Parkinson's	Caffeine
Pacemaker	Fibromyalgia	Rheumatoid Arthritis	Drugs of abuse

Do you exercise regularly? Yes No Are you dieting? Yes No Since: _____

CHECK ANY PROBLEM AREAS THAT YOU HAVE HAD IN THE PAST YEAR:

Muscles-Skelton
Low Back
Middle Back
Neck
Arm(s)
Leg(s)
Shoulder(s)
Knee(s)
Jaw-TMJ
General Stiffness

Nerve System
Headaches
Nervousness
Depression
Numbness/Tingling
Muscular Weakness
Dizziness
Fainting
Convulsions/Seizures
Stress
Shaking/Tremors

Circulation-Breathing
Chest
Breathing
Blood Pressure
Heart
Lungs
Poor Circulation

Digestion-Elimination
Poor Appetite
Excessive Thirst
Nausea
Diarrhea
Constipation
Hemorrhoids
Weight Loss/Gain
Gas/Bloating
Heartburn

Males Only
Prostate Problems
Testicular Problems
Erectile Dysfunction

Eye-Ear-Nose-Throat
Eyes
Dental
Throat
Ear(s)
Nose
Sinus

Urinary-Genitals
Pain Upon Urination
Infrequent Urination
Frequent Urination
Weak Urine Stream
Bladder Control

Females Only
Menstrual Problems
Low Back Pain w/ Periods
Breast Lump(s)/Problems
Hot Flashes
Postmenopausal
Are you Pregnant?
Yes No Not Sure

FAMILY HISTORY: (i.e. heart, cancer, stroke, diabetes, blood pressure, etc.)

Mother's Side: _____

Father's Side: _____

Any Other Problems Not Listed Above : _____

_____

_____ _____

Patient's/Parent's/Legal Guardian's Signature **Date**

Office Use Only
☐ 1
☐ 4-5
☐ >5

Patient #:_____

Pain Drawing

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

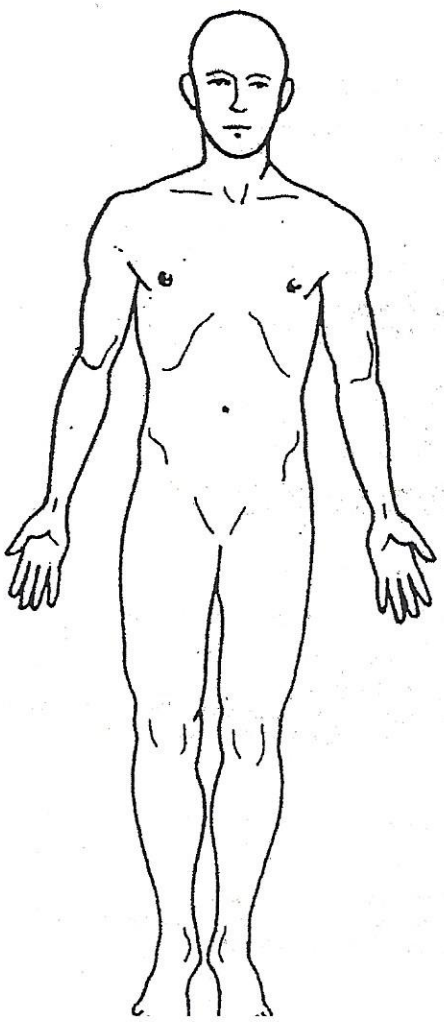
TELL US WHERE YOU HURT.

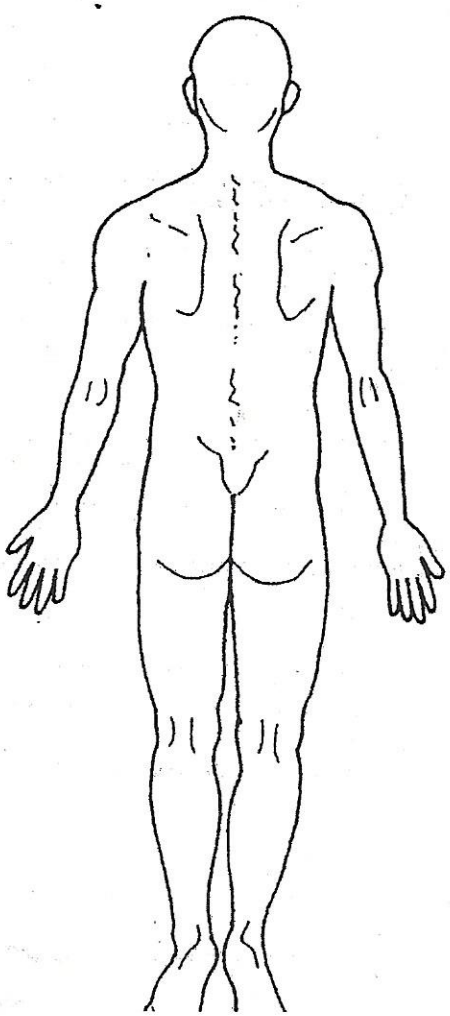
Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~ ~





Informed Consent

Patient Name: _____ Date of Birth: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

The nature of the chiropractic treatment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures if indicated in your treatment:

Spinal manipulation therapy	Graston technique	Orthopedic testing
Ultrasound/laser therapy	Spinal decompression	Postural analysis
Hot/cold therapy	Radiographic studies	Vital signs
Electrical stimulation	Range of motion testing	Basic neurological testing
Exercise	Muscle strength testing	EMS
Massage therapy	Palpation	Other (please explain)

The material risks inherent in chiropractic treatment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. These complication include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check during the taking of your history and during the examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits to such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Dated: _____

_____
Doctor's Name

_____
Signature

ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE
AND DESIGNATION OF DISCLOSURE

Acknowledgement of Health Care Center's Notice of HIPPA Privacy
I have received or read a copy of the Notice of HIPPA Privacy for the Physician's Practice

Patient Name	Date of Birth	Signature of Patient/Parent/Guardian	Date

Designation of Certain Relative, Close Friends and Other Caregivers
I agree that the practice may disclose my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Health Care Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner.
(Check all that apply)

___Home Telephone/Answering Machine
___Work Telephone/Voice Mail
___OK to leave message with detailed information
___OK to leave message with Doctors name
___Leave message with call back numbers only
___Home Address
___Work Address
___OK to mail to my home address
___OK to mail to my work/office address
___Other

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

The following person(s) are NOT allowed to receive my Patient Health Information:

Print Name: _____ Print Name: _____

Please note that if the above sections are NOT completed, we will assume that we have your approval to contact you using any of these methods.

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Uses and disclosures for Treatment, Payment and Health Care Operations may be permitted without prior consent.

I have read the Privacy Notice and DO NOT AGREE to its provisions Signed_____ Date_____

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration for treatment rendered or to be rendered, assigns to the physician or facility named below the following rights, power and authority

RELEASE OF INFORMATION: You are authorize to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for the purpose of processing my claim for benefits and payment of service rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance or state statute. I, as the patient and/or the responsible party, further agree to cooperate and provide information as needed, and appear as needed wherever, to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named below, you are hereby tendered demand for pay in full the bill for services rendered by the physician/facility named below within 60 days following your receipt of such bill for services, to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy. This demand specifically conforms to this state's insurance code, providing for attorney fees, penalty, court costs, collection costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If patient(s) ' treatments for injuries are the result of the negligence of any third party, then patient(s) grant a lien and assignment of cause of action against any right of recovery from such third party(s) to the extent of the bills for treatment, in favor of the physician/facility named below.

INSURANCE AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare my necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. This demand specifically conforms to this state's insurance code, providing for attorney fees, penalty, court costs, and interest from judgment, upon violation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this instrument shall serve as original

_____ _____

Signature of patient and/or responsible party Date

Health Care Center
3525 Mitchell Rd, Bedford, IN 47421

HEALTH CARE CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request and authorize _____ to furnish to

HEALTH CARE CENTER
3525 Mitchell Road
P.O. Box 608
Phone: (812) 275-4419 **Bedford, IN 47421** **Fax: (812) 275-8044**

Access to or copies of the medical records (specified below) for the following person:

Patient's Name: _____
Last First Middle/Maiden

Address: _____

Date of Birth: _____ Social Sec. No.: _____

Telephone No.: _____ Medical Record No.: _____

___Admission History and Physical	___Discharge Summary	___Progress Notes
___Consultations	___Lab Reports	___Pathology Reports
___X-Ray Reports	___X-Ray Films	___Therapy Notes
___Diagnostic Test Results	___Clinic Notes	___Specify other below

_____

For the purpose of: _____

I understand that this authorization is subject to written revocation at any time except to the extent that action has been taken based upon it.

Date: _____ Signature: _____
Patient

Signature: _____/_____
Parent/Guardian Relationship

Witness: _____/_____
If Patient is Unable to sign Reason

Information used or disclosed because of this authorization may be further disclosed by the recipient and would therefore be no longer protected.

Released by: _____ Date: _____