ADVANTACARE
CHIROPRACTIC WELLNESS CENTER

Auto Injury ~Application for Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: ____ Last Name: _____ Gender M / F

SS#:_____-_____-_____ Driver's License #: _____

What do you prefer to be called? _____ DOB: __ __ /__ __ /__ __ Age: _____

Address: _____ City/State/Zip: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Email: _____@_____ Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ Spouse's Occupation: _____

Do you have children? ____Yes ____No # of Children? _____ Children's Ages: _____

EMPLOYMENT

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Volunteer ☐ Other

Business Name: _____Occupation / Job Title: _____

Business Phone: (_____) _____-_____ Is it okay to contact you at work? ____Yes ____No

Type of Tasks Performed/Common Movements: _____

EMERGENCY

Emergency Contact Name: _____ Relationship to you: _____

Address: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____Phone #:_____

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received: ☐ Physical Therapy ☐ Chiropractic Care ☐ Pain Management? Last Visit: _____

REFERRALS

How Did You Hear About This Office? Existing Patient: _____ Other:

Newspaper: _____ Internet: _____ _____

Employee Referral: _____ Community Event: _____

Physician Referral: _____ Phone Book: _____

INSURANCE

Do you have health insurance? Yes No Name of Carrier: _____

Member ID/Policy #: _____ Group #: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

Member ID/Policy #: _____ Group #: _____

PRIMARY INSURED: All of the following information is about the INSURANCE HOLDER

Name of Insured: _____ DOB of Insured: ____/____/_____

Relationship to you(the patient):_____ Employer: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) _____ **DATE** _____

ADVANTACARE Chiropractic Wellness Center 2902 Dolphin Drive Elizabethtown, KY 42701
Dr. Craig A. Bartelt PH: 270.769.2255 Fax: 270.763.9773

Patient Name: _____ Date: _____

PATIENT AUTO INJURY /WORKER'S COMPENSATION INFORMATION SHEET

INSTRUCTIONS: Please complete the information as it relates to the type of Personal Injury you have experienced.
We must have this form completed in its entirety upon your arrival here at ADVANTACARE.
This information is used for billing purposes only. If you do not have this information available at this time, please let a staff member know.

Patient Name: _____

Date of Accident/Injury/Loss: _____

In what state did your accident occur? _____

☐ **AUTO ACCIDENT INSURANCE INFORMATION**

If you have not completed an application of benefits from you auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier: _____

Auto Insurance Carrier Phone #: _____ Ext. _____

Insurance Carrier Address: _____

_____

Claim Adjuster's Name: _____

Claim Number: _____

☐ **WORKER'S COMPENSATION INFORMATION**

An accident report must have been filed with your employer for charges to be covered and a workers compensation form must also be completed. If our clinic is not part of your employer's worker's compensation panel, you may be required to go to a panel provider for and initial visit before requesting transfer of your case to this office. If you are unsure if we are part of your employer's panel, please ask a member of our staff for assistance.

Employer:

_____

Employer's Phone #: _____ Ext. _____

Employer's Address: _____

_____

Human Resource Manager's Name: _____

Claim Number: _____

Patient Name: _____ Date: _____

AUTO ACCIDENT HISTORY

INSTRUCTIONS. Please complete questions 1 through 67 to the best of your ability. Be as descriptive as possible and check all descriptors that apply. This form was designed to reduce the time involved in taking your initial history. In doing so, we are able to spend more time on determining the nature of your current problem through examination procedures. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

HISTORY OF OCCURRENCE

Date of the Accident ____/_____/_____

1. I was the/a: Pedestrian Driver Passenger- Left Front Passenger- Center Front Passenger- Right Front Passenger- Left Rear Passenger- Center Rear Passenger -Right Rear
2. Patient Vehicle Type *(What type of car were you driving?)*
   Compact Mid-size Full-size SUV Pick-up Motorcycle Other _____
3. Second Vehicle Type *(What was the opposing car type?)*
   Compact Mid-size Full-size SUV Pick-up Motorcycle Other _____ 4. Third Vehicle Type:

   Compact Mid-size Full-size SUV Pick-up Motorcycle Other _____
5. Road Conditions:
   Dry Icy Wet Clear Foggy Dark Other _____
6. Road Type:
   Concrete Asphalt Gravel Dirt Other _____
7. Were you aware the accident was going to occur? Yes No
8. Were you wearing a seatbelt? Yes No
9. Did your airbag deploy? Yes No
10. Does your car have a headrest? Yes No
11. What position was the headrest in? Up Middle Down
12. Head Position: *(At the time of the accident were you looking…)* Straight AheadLeft Level
    Left Up Left Down Right Level Right Up Right Down Looking Up Looking Down
13. Were you pushing the brake (stopping) either during or before impact?Yes No
14. Was your car moving before impact? Yes No
    If yes, how fast? (mph)<5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70
15. Was the driver of the second vehicle braking (stopping) Yes No
16. Was the second vehicle moving before impact? Yes No
    If yes, how fast? (mph)<5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70
17. Was the driver of the third vehicle braking (stopping)? Yes No
18. Was the third vehicle moving before impact? Yes No
    If yes, how fast? (mph.) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

COLLISION DETAILS *(Describe how the cars collided. My vehicle was…)*

19. First Impact: Hit By Another Vehicle Hit Another Vehicle Hit By An Object Hit An Object
    (My car was hit in the…) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top
20. Second Impact:Hit By Another Vehicle Hit Another Vehicle Hit By An Object Hit An Object
    (My car was hit in the…) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

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Patient Name: _____ Date: _____

COLLISION RESULTS *("During the accident my…")*

21. Body was thrown: Backward Forward Left Right Can't Remember
22. Head Hit: Airbag Another Person's Body Back Of Front Seat Dashboard Front Windshield Rear-View Mirror Side Window/Door Steering Wheel
23. Chest Hit: Another Person's Body Back Of Front Seat Dashboard Side Window/Door Steering Wheel
24. Shoulders Hit: Another Person's Body Back Of Front Seat Shoulder Harness Side Window/Door
25. Knees Hit: Another Person's Body Back Of Front Seat Center Console Dashboard Door Panel Steering Wheel
26. Hips Hit: Another Person's Body Back Of Front Seat Center Console Dashboard Door Panel Steering Wheel

VEHICLE DAMAGE

27. First Vehicle: Totaled Significant Damage Light Damage No damage
28. Second Vehicle: Totaled Significant Damage Light Damage No damage
29. Third Vehicle: Totaled Significant Damage Light Damage No damage

PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4).

Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.

MOST SEVERE **LEAST SEVERE**

You have the following complaints (WRITE-IN)	**1.**	**2.**	**3.**	**4.**
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

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Patient Name: _____ Date: _____

PERSONAL INJURY

30. Were you hospitalized?YesNo *(If yes, please answer the questions in the paragraph below.)*

⇒ When were you hospitalized? Date ____/_____/_____
Immediately Later The Same Day The Next Day.

⇒ How were you transported to the hospital? Ambulance Life Flight Private Transportation

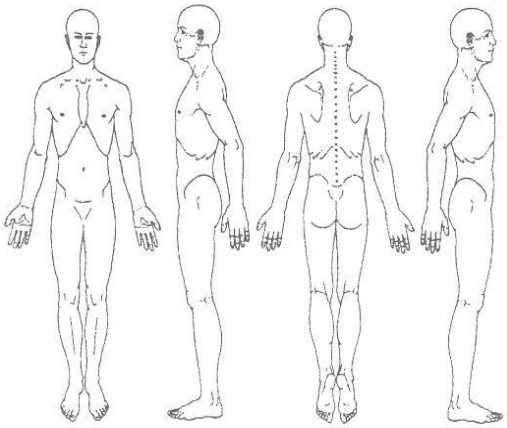
⇒ What did the hospital recommend? No Instructions See This Clinic See DC
See Own Doctor See Neurologist See Orthopedist
Over The Counter Medication Prescription Medication
Other: _____

⇒ Did you have any x-rays, CT Scans or MRI's taken?YesNo If yes, what areas? _____
_____

31. How would you describe your current symptoms: PainNumbness StiffnessWeakness

32. Describe the quality of your symptoms:Burning PainDiffuse Dull/Aching Localized
Radiating Sharp Shooting Stabbing
ThrobbingTightness Tingling
Other _____

33. Please mark the area of your symptoms:



34. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has **on your daily functioning when you are at rest**? (*Circle*)

0 1 2 3 4 5 6 7 8 9 10

35. On the same scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has **on your daily functioning when you are active**? (*Circle*)

0 1 2 3 4 5 6 7 8 9 10

36. Is your condition currently… Worsening Improving Unchanged ?

37. If you condition has worsened or is worsening, when did the increased symptoms start? _____

38. When was the last time you experienced these symptoms? _____

39. Is your condition is worse in the: Morning Afternoon Night With Activity
and is it mostly:Intermittent Constant throughout the day.

40. Is your condition better in: Warm Temp Cold Temp Neither

41. Is your condition worse in: Warm Temp Cold Temp Damp None

42. Check any of the following signs or symptoms that are associated with your current condition:
Headaches (Describe your headaches in detail): _____
_____

Blurred Vision	Depression	Irritability / Mood Swing		Radiating Pain	
Localized Tingling	Nausea	Ringing in Ears	Stiffness	Weakness	Aches
Cold Limb	Dizziness	Ecchymosis	Fatigue	Fever	Heartburn
Muscle Spasm	Numbness	Pale Bluish Skin	Panic	Pins & Needles	Runny Nose
Short Breath	Sweating	Swelling	Tingling	Vomiting	

43. Do your symptoms seem to be better with:
Nothing Activity Bending Cold Over-The-Counter Heat Massage Movement
Medications Prescription Medications Rest Stretching Sitting
Standing Twisting Walking

Patient Name: _____ Date: _____

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

44. Please list any medications or nutritional supplements that you are currently taking:

_____

45. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided:

_____

46. Childhood Illnesses (Please list any illnesses that you have had as a child): _____

47. Adult Illnesses (Please list any illnesses that you have had as an adult):_____

48. Surgeries (Please list all surgical procedures that have had in the past)

_____

49. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past):

_____

50. Non Drug Allergies and how you react to those substances:

_____

FAMILY HISTORY

This section will identify any possible genetic characteristics or risk factors that may impact or contribute to your current health condition.

51. Please describe your family history:

General Family	Alive	Deceased	Health Conditions / Diseases / Conditions
Father			_____
Mother			_____
Paternal Grandfather			_____
Paternal Grandmother			_____
Maternal Grandfather			_____
Maternal Grandmother			_____
Son(s)			_____
Daughter(s)			_____
Brother(s)			_____
Sister(s)			_____

52. Please describe your condition's effect on your activities of daily living (ADL's):

Caring for Infirm Family:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Carrying Groceries:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Change Position (Sit to Stand):	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Climbing Stairs:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Daily Pet Care:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Driving:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Extended Computer Use:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Household Chores:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Lifting Children:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Self Care–Bathing/Dressing:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Sexual Activities:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Sleeping:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Static Sitting:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Static Standing:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Walking:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
Yard Work:	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform

Patient Name: _____ Date: _____

SOCIAL & WORK HISTORY cont….

53. Please list any recreational activities or hobbies and describe your condition's effect on those activities:

List: _____	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
List: _____	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
List: _____	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform
List: _____	No Effect	Painful (I can do it)	Painful (I'm limited)	Unable to Perform

54. Please describe you current employment status:Student (Part / Full Time)UnemployedRetired
Homemaker Not Working Not Working (Summer Break) Partially Disabled (%___) 100% Disabled Disabled Veteran (%___) 100% Disabled Veteran Currently Employed as a: _____

55. How would you classify your job based on the following lifting limits?
Sedentary (Less than 5 lbs.) Light (6 to 20 lbs.) Moderate (21 to 49 lbs.)
Heavy (Greater than 50 lbs.)

56. How often do you lift at your job?
Constant (66 to 100% of the day) Frequent (33 to 65% of the day) Occasional (0 to 32% of the day)

57. Lifting Postures at work: Sitting Kneeling/Stooping Arms Up Shoulder Standing Other Abnormal Position:_____

58. How many hours per day do you do each of the following activities?
Sitting: _____Standing: _____Walking: _____Climbing: _____Pushing: _____
Pulling: _____Kneeling: _____Reaching: _____Twisting: _____

59. If you lift at work, what type of lifting is most frequent? Torso LevelKnee Level Floor Level
Arm Level Shoulder Level High and Near Off Posture / Off Balance Standing & Twisting Standing, Twisting & Bending Sitting & Twisting Sitting, Twisting & Bending Other (Explain):
_____

60. Please describe your condition's effect on your job performance:
No Effect Painful (I can do it) Painful (Limited Ability) Painful (Limited Duty)
Unable to Perform (No Limited Duty)Unable to Perform (Can Not Do Limited Duty)

Is there any other information that you feel would be relevant to your current condition that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case:

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____ /_____/_____