Synergy Chiropractic & Physical Therapy
31360 Via Colinas Drive Suite 104 Westlake Village, CA 91362
(805) 492-1500

PERSONAL INJURY INTAKE FORM

PERSONAL DATA

Today's Date: _____ Date of Accident: _____

Name: _____ Age:_____ DOB:_____ Sex: M F

Address:_____

City:_____ State:_____ Zip:_____

Cell Phone (_____)_____ SSN:_____ Driver's Lic. #_____

Email: _____

Are you/have you been disabled from work?_____

Who can we thank for referring you?_____

In case of emergency, notify_____

Relationship:_____**Phone(**_____**)**_____

AUTO INSURANCE INFORMATION

Who is the insured person on your policy?_____

Name of your insurance company: _____

Address: _____

Phone # of insurance company:_____ Policy #:_____

Accident Claim #_____ Who was at fault? (Name)_____

Have you contacted an insurance adjuster or representative regarding this claim ☐ No ☐ Yes

If yes Adjuster name: _____ Adjuster Phone: _____

Is there medical payments (Med Pay) coverage: ☐ No ☐ Yes What is the med-pay limit? _____

Have you filed an injury report? ☐ No ☐ Yes

OTHER PARTIES' INSURANCE COMPANY (if applicable):

Company:_____ __

Address:_____ _____ Phone #:_____

Policy #:_____ Claim #:_____

Do you have additional Insurance? NO YES

Name of Insured_____ Relationship to patient_____

DOB_____ SS#_____ Date employed_____

Address_____ Insurance Company_____

Group #_____ Employer #_____

Informed Consent
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 if there is anything that is unclear.

The nature of the chiropractic adjustment:
The primary treatment used by doctors 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 part of the analysis, examination, and treatment, you are consenting to the following procedures

- Range of motion
- Orthopedic Testing
- Basic Neurological Testing
- Muscle Strength Testing
- Ultrasound
- Hot/Cold Therapy
- Posture Analysis Test
- EMS
- Other: all physiotherapy in the office including but not limited to laser, PEMF, compression boots, traction, etc…….

The risks inherent in chiropractic adjustment and risk of physical therapy:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following for the first few days of treatment. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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 painkillers
- 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 of such options and you may want to discuss these with your primary 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.

As of this date, I have the legal right to select and authorize health care services for the minor child above. (If applicable) under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

_____ I have read OR_____ I have had read to me:

The above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(the doctor and/or staff*) 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 risks, I hereby give my consent to that treatment.

Patient name (print)_____

Patient signature_____ Date _____

PHYSICAL THERAPY

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to specific modality, or exercise protocol. C.P.P.T. does not guarantee that your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your treating physical therapist throughout your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient name (print)_____

Patient signature_____ Date _____

HIPPA Compliance

Synergy Chiropractic & Physical Therapy is required by law to maintain the HIPAA Notice of Privacy Practicies. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____Date:_____

Witness _____

Staff Initials_____

Consent for Treatment of a Minor

I hereby authorize all Synergy Chiropractic and Physical Therapy employees to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____.

Guardian Name (print):_____

Guardian Signature_____ Date_____

VEHICLE ACCIDENT INFORMATION

ACCIDENT SITE:
City/ State:_____
Speed you were traveling:_____
Speed other car was traveling_____

POLICE:

Were there any witnesses?	☐ No	☐ Yes
Was a police report filed?	☐ No	☐ Yes
Did Ambulance come?	☐ No	☐ Yes
Did you go to hospital?	☐ No	☐ Yes

Make and model of car:
_____
Make and model of other car_____

Were you wearing a seat belt?	☐ No	☐ Yes
Was vehicle equipped with air bags?	☐ No	☐ Yes
Did the airbags deploy?	☐ No	☐ Yes
Was the car totaled?	☐ No	☐ Yes
Did you lose consciousness?	☐ No	☐ Yes
Did your body hit anything?	☐ No	☐ Yes

If yes explain_____

ATTORNEY

Have you engaged the services of an attorney: ☐ No ☐ Yes

Attorney: _____

Address_____City:_____

State:_____ Zip:_____ Phone:_____ Fax:_____

ACCIDENT INJURY

In your own words, please describe the accident: _____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT ☐ No ☐ Yes

If yes, please describe: _____

Do you have any previous illnesses that relate to this case? ☐ No ☐ Yes Please describe:

Have you ever been in an accident before? ☐ No ☐ Yes if yes please describe, including date(s) and types(s) of accidents, as well as injury(ies) received: _____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATLEY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

How do you feel? ☐ Confused ☐ Weak ☐ Dazed ☐ Nervous ☐Other: _____

WORK & THIS INJURY

Have you missed work due to this accident/injury? ☐ Missed No Work ☐ Limited Work Activity

a. Missed Work From _____/_____/_____ To: _____/_____/_____

b. Last Day Worked:_____

c. Type of Employment:_____

FOR THIS INJURY

Did you go to the hospital or urgent care? ☐Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next Day ☐ 2 Days or more after the accident

How did you get to the hospital/UC? ☐ Ambulance ☐ Private Transportation

Name of hospital/UC:_____ Name of Doctor:_____

Diagnosis:_____

_____

Treatment received:_____

_____

X-ray/CT/MRI taken: ☐Yes ☐ No , Body parts:_____

Did you self-treat your symptoms? ☐Ice ☐ Heat ☐Bed Rest ☐ Over-the-counter-medication ☐ Other:_____

If there were lacerations (cuts), where were they?_____

CURRENT COMPLAINTS

TREATMENT

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

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

□ Headache □ Irritability □ Numbness in Toes □ Face Flushed □ Feet Cold □ Chest Pain □ Shortness of Breath

□ Neck Pain □ Hands Cold □Buzzing in Ears □ Dizziness □ Fatigue □ Loss of Balance □ Head seems too Heavy

□ Neck Stiff □ Depression □ Fainting □ Constipation □ Back Pain □ Pins & Needles in Arms or Legs

□ Lights Bother Eyes □ Sleeping Problems □ Loss of Smell □ Cold Sweats □ Nervousness □ Loss of Memory

□ Loss of Taste □ Fever □ Tension □ Ears Ringing □ Diarrhea □ Leg Pain □ Numbness in Fingers

□ Arm/Shoulder Pain □ Back Stiffness □ Jaw Problems □ Nausea □ Blurred Vision

Symptoms Other Than Above:_____

Since your accident/injury have you suffered from any of the following:

□ Blurred Vision □Double Vision □ Reduced Vision □ Impaired Hearing □ Ringing in Ears □Chest Pain

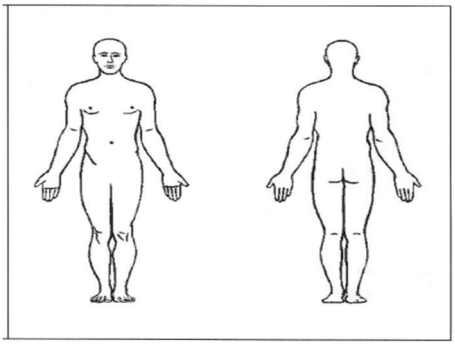
□ Difficulty Breathing □Palpitations □ Constipation □ Nausea □ Vomiting □Frequent Urination

□ Inability to Hold Urine □ Painful

Please complete the attached MUSCULO-SKELETAL form as thoroughly as possible, checking all appropriate boxes to document your CURRENT complaints and symptoms.

#1 PAIN COMPLAINT: _____

1. **When did your symptoms appear?**
   Date of onset: _____ Was it: □ Sudden □ Gradual
2. **Is this condition getting progressively worse?** □ Yes □ No □ Unknown
3. **Describe your pain/complaint**
   □ Dull □ Sharp □ Ache □ Stabbing
   □ Deep □ Superficial □ Spasm/tension □ Numbness
   □ Tingling □ Burning □ Stiffness □ Pulling
4. **Radiation: Does the pain go to other parts of the body?**
   □ Yes □ No Where: _____
5. **Degree; what is the degree of your pain?**
   □ Mild □ Moderate □ Severe
6. **Frequency: How often do you have this pain?**
   □ Occasional □ Intermittent □ Frequent □ Constant
7. **Duration: how long does the pain last?** _____
8. **What makes the pain worse?**
   □ Standing □ Sitting □ Bending □ Twisting
   □ Walking □ Lifting □ Sleeping □ Heat
   □ Cold □ Stooping □ Sex □ Other
9. **What makes the pain better?**
   □ Sitting □ Standing □ Rest □ Cold □ Heat
   □ Aspirin/medication □ Other:_____ __
10. **Does it interfere with your:**
    □ Work □ Sleep □ Daily routine □ Recreation
11. **What treatment have you already received for this condition**
    □ Medications □ Surgery □ Physical Therapy □ Chiropractic Servies □ None □ Other:_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

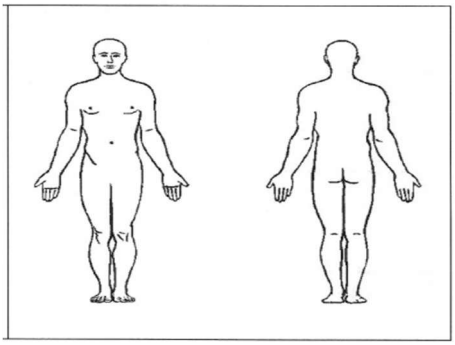
Please RATE YOUR PAIN!

Please circle the accurate pain level below (1-low; 10-high)

1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT: _____

1. **When did your symptoms appear?**
   Date of onset: _____ Was it: □ Sudden □ Gradual
2. **Is this condition getting progressively worse?** □ Yes □ No □ Unknown
3. **Describe your pain/complaint**
   □ Dull □ Sharp □ Ache □ Stabbing
   □ Deep □ Superficial □ Spasm/tension □ Numbness
   □ Tingling □ Burning □ Stiffness □ Pulling
4. **Radiation: Does the pain go to other parts of the body?**
   □ Yes □ No Where: _____
5. **Degree; what is the degree of your pain?**
   □ Mild □ Moderate □ Severe
6. **Frequency: How often do you have this pain?**
   □ Occasional □ Intermittent □ Frequent □ Constant
7. **Duration: how long does the pain last?** _____
8. **What makes the pain worse?**
   □ Standing □ Sitting □ Bending □ Twisting
   □ Walking □ Lifting □ Sleeping □ Heat
   □ Cold □ Stooping □ Sex □ Other
9. **What makes the pain better?**
   □ Sitting □ Standing □ Rest □ Cold □ Heat
   □ Aspirin/medication □ Other:_____ __
10. **Does it interfere with your:**
    □ Work □ Sleep □ Daily routine □ Recreation
11. **What treatment have you already received for this condition**
    □ Medications □ Surgery □ Physical Therapy □ Chiropractic Servies □ None □ Other:_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

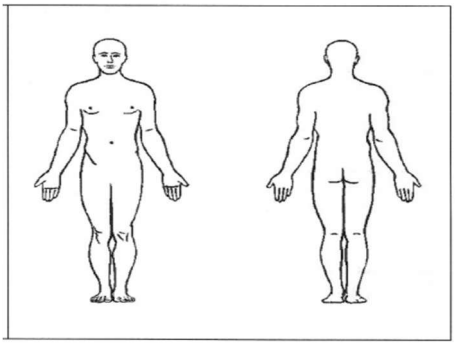
Please RATE YOUR PAIN!

Please circle the accurate pain level below (1-low; 10-high)

1 2 3 4 5 6 7 8 9 10

#3 PAIN COMPLAINT: _____

1. **When did your symptoms appear?**
   Date of onset: _____ Was it: □ Sudden □ Gradual
2. **Is this condition getting progressively worse?** □ Yes □ No □ Unknown
3. **Describe your pain/complaint**
   □ Dull □ Sharp □ Ache □ Stabbing
   □ Deep □ Superficial □ Spasm/tension □ Numbness
   □ Tingling □ Burning □ Stiffness □ Pulling
4. **Radiation: Does the pain go to other parts of the body?**
   □ Yes □ No Where: _____
5. **Degree; what is the degree of your pain?**
   □ Mild □ Moderate □ Severe
6. **Frequency: How often do you have this pain?**
   □ Occasional □ Intermittent □ Frequent □ Constant
7. **Duration: how long does the pain last?** _____
8. **What makes the pain worse?**
   □ Standing □ Sitting □ Bending □ Twisting
   □ Walking □ Lifting □ Sleeping □ Heat
   □ Cold □ Stooping □ Sex □ Other
9. **What makes the pain better?**
   □ Sitting □ Standing □ Rest □ Cold □ Heat
   □ Aspirin/medication □ Other:_____ __
10. **Does it interfere with your:**
    □ Work □ Sleep □ Daily routine □ Recreation
11. **What treatment have you already received for this condition**
    □ Medications □ Surgery □ Physical Therapy □ Chiropractic Servies □ None □ Other:_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

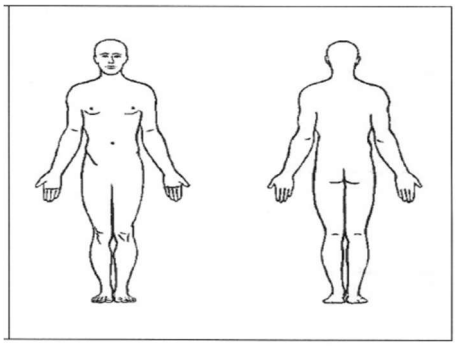
Please RATE YOUR PAIN!

Please circle the accurate pain level below (1-low; 10-high)

1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT: _____

1. **When did your symptoms appear?**
   Date of onset: _____ Was it: □ Sudden □ Gradual
2. **Is this condition getting progressively worse?** □ Yes □ No □ Unknown
3. **Describe your pain/complaint**
   □ Dull □ Sharp □ Ache □ Stabbing
   □ Deep □ Superficial □ Spasm/tension □ Numbness
   □ Tingling □ Burning □ Stiffness □ Pulling
4. **Radiation: Does the pain go to other parts of the body?**
   □ Yes □ No Where: _____
5. **Degree; what is the degree of your pain?**
   □ Mild □ Moderate □ Severe
6. **Frequency: How often do you have this pain?**
   □ Occasional □ Intermittent □ Frequent □ Constant
7. **Duration: how long does the pain last?** _____
8. **What makes the pain worse?**
   □ Standing □ Sitting □ Bending □ Twisting
   □ Walking □ Lifting □ Sleeping □ Heat
   □ Cold □ Stooping □ Sex □ Other
9. **What makes the pain better?**
   □ Sitting □ Standing □ Rest □ Cold □ Heat
   □ Aspirin/medication □ Other:_____ __
10. **Does it interfere with your:**
    □ Work □ Sleep □ Daily routine □ Recreation
11. **What treatment have you already received for this condition**
    □ Medications □ Surgery □ Physical Therapy □ Chiropractic Servies □ None □ Other:_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!

Please circle the accurate pain level below (1-low; 10-high)

1 2 3 4 5 6 7 8 9 10

I hereby verify that all the above information is correct and accurate.

Patient Name:_____ Patient Signature:_____ Date:_____

PHYSICIAN'S LIEN

Attorney: _____ Date:_____

Patient Name: _____

I do hereby authorize Synergy Chiropractic and Physical Therapy to furnish you, my attorney, with a full report of their 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 my medical service rendered to me both by reason of this accident and by reason of any other bills that are due to their office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect 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 injuries for which I have ben treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not e honored by my attorney. I hereby instruct that in the event another is substituted in this matter, the new attorney shall honor this lien as inherent to settlement and enforceable upon the case as if it were executed by them.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by them 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 also understand my account will be charged interest at the rate of 1.5 % monthly after 90 (ninety) days from my initial office consultation.

In the event any party to this lien commences legal proceedings against the other to enforce the terms hereof, or to declare rights there under as the result of any breach of any covenant or condition of this lien, the prevailing party in any such proceeding shall be entitled to recover from the losing party its cost of suit, including reasonable attorney's fees, as may be fixed by the court.

Please acknowledge this letter by signing 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 will require me to make payments on a current basis.

Date:_____ _____

Patient's signature

The undersigned by attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold sums from any settlement, judgement, or verdict, as may be necessary to adequately protect said doctor named herin.

Date:_____ _____

Attorney's Signature