AUTO ACCIDENT (CHIRO OR PT):

Date of accident: _____ **Location of accident (City/County/State/General Area):** _____
Time of accident: _____**am/pm** **Have you filed an auto claim for your injuries (circle):** YES / NO

Your car: Make: _____ **Other car: Make:** _____
Model: _____ **Model:** _____
Year: _____ **Year:** _____
Speed of your vehicle at impact (mph): _____ **Speed of the other vehicle at impact (mph):** _____

Your position in vehicle (circle): driver / front passenger / back right passenger / back left passenger (behind driver)

Driving Conditions: Weather (circle): clear / sunny / foggy / cloudy / rainy / snowy / other _____
Road (circle): dry / wet / icy / snowy / other _____
Visibility (circle): good / fair / poor / other _____

Action of patient's vehicle:
□ crossing an intersection
□ stopped at an intersection
□ stopped for a pedestrian
□ stopped in traffic
□ turning left
□ turning right
□ traveling at the posted speed limit
□ traveling faster than the speed limit
□ traveling slower than the speed limit

Body position at impact:
□ sitting straight
□ leaning forward
□ turned to the left
□ turned to the right
□ slouched down in the seat
□ holding onto the steering wheel

What happened to your vehicle:
□ hit head-on
□ hit on the left front
□ hit on right front
□ hit on left rear
□ was rear-ended
□ was side-swiped on left
□ was side-swiped on right
□ was t-boned
□ turning right
□ hit the other vehicle head-on
□ hit the other vehicle on left front
□ hit the other vehicle on right front
□ hit the other vehicle on the left rear
□ hit the other vehicle on the right rear
□ rear-ended the other vehicle
□ side-swiped other vehicle on left
□ side-swiped other vehicle on the right

Damage to your vehicle:
□ complete
□ extensive
□ moderate
□ minimal

Damage to the other vehicle:
□ complete
□ extensive
□ moderate
□ minimal

Restraint:
Were you wearing seatbelt? YES / NO
If no, why: _____

Head rest position (circle): High
Low
Don't recall

Did head hit head rest? YES / NO
Did head go over head rest: YES / NO

Direction body thrown:
□ backward then forward
□ forward then backward
□ to the left
□ to the right
□ ejected from the vehicle

Head position at impact:
□ straight
□ tilted forward
□ turned to left
□ turned to right

Direction head was thrown:
□ backward then forward
□ forward then backward
□ side to side

Direction vehicle was moved:
□ forward
□ backward
□ sideways

Action of vehicle after impact (circle): rolled / spun / neither
Were the brakes being applied (circle): YES / NO
Was the ankle of the driving foot turned (circle): YES / NO
Did the airbags deploy (circle): YES / NO

Did you hit anything at impact? Y / N
If yes, check which part of the vehicle you hit and list which body part(s) hit it (head, right or left arm, etc.).
□ Dashboard:_____
□ Windshield:_____
□ Door:_____
□ Seat:_____
□ Steering wheel:_____
□ Ceiling:_____
□ Side window:_____
□ Loose objects:_____

▪**Describe any details of the accident that WERE NOT already asked:**
_____
▪**List the body parts that were reported as injuries to your auto insurance company:** _____
▪**Did you have pain in the above area(s) PRIOR to the auto accident?** Y / N
▪**Dates of any PREVIOUS accidents:**_____
▪**Injuries from PREVIOUS accidents:**_____
▪**Date last worked IF you have been off work since the accident:**_____
▪**If you were placed on disability since the accident indicate by whom and the date the disability started:**_____
▪**List other doctors seen for this accident:**_____
▪**Anyone else in vehicle?** Y / N ▪**Did they seek treatment?** Y / N/ UNKNOWN

FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

AUTO ACCIDENT CHIRO OR PT:
PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____
Email: _____ Emergency Contact Name / # / Relationship: _____/_____/_____
Primary Care Physician/Facility:_____ Primary Care Phone:_____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation
ARE YOU CURRENTLY PREGNANT? YES NO

CHIEF COMPLAINT: **Answer the questions as completely as possible. If a question does not apply, leave it blank.**

Reason for today's appointment: ☐ Neck pain ☐ Upper back pain ☐ Low back pain ☐ Other: _____

Which side of your body is the complaint on? ☐ Right ☐ Left ☐ Both

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Intermittently (26-49%) ☐ Occasionally (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

How does this effect your movement?
☐ Stiffness ☐ Spasms ☐ Cramps

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

Please add any other information about the primary complaint that may be helpful:
_____

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

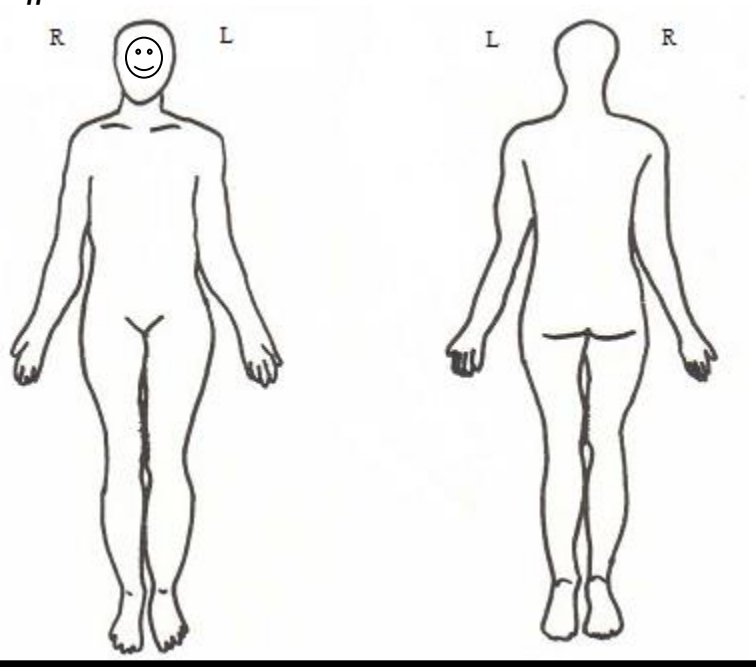
PATIENT'S INITIALS_____DATE_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	=======
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / Achy pain	……
Sharp / Stabbing pain	///////////////



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain ——— **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐

ALLERGIC/IMMUNOLOGIC: ☐ **NONE** Food Allergies/sensitivities Seasonal allergies/Hay fever Hives

CARDIOVASCULAR: ☐ **NONE** Ankle swelling Blood clots Chest pain Feeling light headed with standing Heart murmur
Heart problems High blood pressure High cholesterol Leg pain with walking short distances Low blood pressure
Palpitations (heart skipping beats) Poor circulation Rapid heartbeat Sores that don't heal Varicose veins

CONSTITUTIONAL: ☐ **NONE** Chills Difficulty concentrating Difficulty sleeping Fatigue Fainting Fever Low libido
Nervousness Night Sweats Poor appetite Weakness

EARS, NOSE &THROAT: ☐ **NONE** Blisters/cold sores Chronic ear infection Dental problems/toothaches Deviated septum
Dry mouth Dysphagia/trouble swallowing Ear noises/ringing Ear pain Gum disease Hearing loss Loss of smell Loss of taste
Loss of teeth/ have dentures Motion sickness Nose bleeds Nasal breathing problems Nasal drip Nasal polyps Recurrent ear infections
Sinus infections/pain Sore throat/hoarseness Sores/ulcers Tonsillitis Vertigo/dizziness

ENDOCRINE: ☐ **NONE** A loss of appetite Being unusually jumpy or nervous Changes in hair growth or distribution Cold intolerance
Excessive hunger Excessive thirst Feeling drowsy after eating Feeling shaky or faint when hungry Heat intolerance Hyperthyroid
Hypothyroid Type I diabetes Type II diabetes Unexplained weight gain Unexplained weight loss

EYES: ☐ **NONE** Burning in the eyes Blurred vision Cataracts Dry or gritty eyes Far sightedness Glaucoma Itchy eyes
Near sightedness Redness Swelling Tearing/crusting Vision headaches

GASTROINTESTINAL: ☐ **NONE** Abdominal gas Abdominal pain Acid reflux/heart burn Anorexia/Bulimia Constipation
Diarrhea Discolored stool Frequent indigestion Gall bladder disease Hemorrhoids Liver disease Nausea Stomach Ulcers Vomiting

GENITOURINARY: ☐ **NONE** A discharge other than urine Bedwetting Bladder control problems Cloudy/foul smelling urine
Difficulty starting a stream Discolored urine Dribbling Endometriosis Erectile dysfunction Frequent urination
Getting up at night to urinate Infertility Kidney stones Kidney or bladder infections Painful urination PMS symptoms Urgency
Uterine cysts Uterine fibroids

HEMATOLOGIC/LYMPHATIC: ☐ **NONE** Anemia Bleeding or bruising Blood clots Hemophilia Hepatitis A Hepatitis B
Hepatitis C HIV/AIDS Jaundice Liver problems Lymphoma Myeloma Swollen Glands

INTEGUMENTARY/SKIN: ☐ **NONE** Acne Bruising Dandruff Dryness Eczema Excessive Sweating Nail fungus
Plantar warts Psoriasis Rashes Skin cancer Sores

MUSCULOSKELETAL: ☐ **NONE** Arthritis Back injuries Back pain General muscle tension Heel spurs Joint pain
Joint stiffness Joint swelling Leg/foot cramps during the day Leg/foot cramps when retiring to bed or at night Muscle cramps Muscle pain
Muscle Weakness Neck injuries Neck pain Pain between the shoulders Painful feet Rheumatoid arthritis Scoliosis TMJ pain

NEUROLOGICAL: ☐ **NONE** Confusion Convulsions Difficulty of speech Double vision Epilepsy Fainting spells
Headaches Incoordination Losing consciousness Loss of feeling Memory loss Meningitis Muscle jerking/twitching/tics
Numbness/tingling Paralysis Pins/needles Seizures Stuttering

PSYCHIATRIC: ☐ **NONE** Alcoholism Anxiety Considerable emotional stress Crying often Depression
Drug addictions/dependency Eating when nervous Extreme worry Feeling angered or irritable Hallucinations Insecurity Nail biting
Phobias Recurrent bad dreams Sleep walking Suicidal thoughts

RESPIRATORY: ☐ **NONE** Apnea Asthma Congestion COPD Coughing up blood Difficulty breathing Emphysema
Non-productive/dry cough Pneumonia Productive cough Shortness of breath Wheezing

FAMILY HISTORY: Please select the conditions that pertain to your family. (If known)

Relative:	Age: (if living)	Conditions/Illnesses:	Age at death:
Mother:	_____	_____	_____
Father:	_____	_____	_____
Sibling #1:	_____	_____	_____
Sibling #2:	_____	_____	_____

SOCIAL HISTORY: Please answer as completely as possible.

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Indigenous Person ☐ Other_____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other_____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Marital Status: _____

Number of children: ____ **Number of Pregnancies:** ____ **Number of miscarriages:** ____ **Number of abortions:** ____

Highest level of education: _____

Do you feel that you eat a well-balanced diet? _____

How often do you exercise? _____ **What types of exercises?** _____

How often do you drink alcohol? _____

Cigarette Smoker: ☐ Never ☐ Current: Amt per day: _____ ☐ Former: Quit Date: _____

Smokeless Tobacco/Chew: ☐ Never ☐ Current: Amt per day: _____ ☐ Former: Quit Date: _____

Have you ever used illegal drug? (circle) YES NO If you use illegal drugs now, which ones? _____

Have you ever been treated for substance abuse? (circle) YES NO

Are your vaccinations up to date? (circle if known) YES NO

First date of last menstrual period (LMP): _____

SURGICAL HISTORY:

Please list any surgeries that you have had in the past and the date if known. Also INCLUDE RIGHT OR LEFT side of body where applicable.

☐ **I have never had any previous surgery**

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list any allergies as well as your reaction to the allergen if known.

Environmental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	

PHARMACY NAME:_____ LOCATION:_____ PHONE #:_____

The STarT Neck Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	**Agree** 1
1	My neck pain has **spread down my arm(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **hip** or **back** at some time in the last 2 weeks	☐	☐
3	I have dressed/washed more slowly because of my neck pain	☐	☐
4	In the last few days, my sleeping is moderately disturbed because of neck pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my neck pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your neck pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 0	☐ 0	☐ 1	☐ 1

Total score (all 9): _____ Sub Score (Q5-9):_____

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	**Agree** 1
1	My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3	I have only **walked short distances** because of my back pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient signature_____**Date**_____

Authorization and Assignment

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Total Health Systems, PC.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT *(if applicable)*: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

ACKNOWLEGMENT AND UNDERSTANDING: I hereby acknowledge;

That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copay/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

Patient signature_____**Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, ACUPUNCTURE, AND/OR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, strains, bleeding, bruising, and infection. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient signature_____**Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____**Date**_____

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Total Health Systems, P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

26672 Van Dyke ● Centerline ● Michigan 48015 ● (586) 756-7670
43740 Garfield ● Clinton Township ● Michigan 48038 ● (586) 228-0270
28098 23 Mile Rd ● Chesterfield Township ● Michigan 48051 ● (586) 949-0123
30045 Harper Ave ● St Clair Shores ● Michigan 48082 ● (586) 772-8560
57911 Van Dyke Rd ● Washington Township ● Michigan 48094 ● (586) 781-0800
Fax (586) 228-9019
www.totalhealthsystems.com

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage • Nutrition • Fitness

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed. The information covered by this authorization includes:

X-Rays History Diagnosis Treatment Reports
Other: _____

Persons Authorized to Use or Disclose Information:

_____
Primary Care Physician PCP Telephone # / Fax

_____
Other Treating Providers Telephone # / Fax

_____
Family Member, POA, or Guardian Telephone # / Fax

Please be advised that Total Health Systems is a *Patient Centered Medical Home*. We will coordinate your care and disclose your information with your PCP if authorized.

Expiration Date of Authorization
This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient or Legally Authorized Individual Signature Date & Time

_____ _____
Print Patient's Full Name Date of Birth (XX/XX/XXXX)

_____ _____
Witness Signature Date

26672 Van Dyke ● Centerline ● Michigan 48015 ● (586) 756-7670
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