Integrative Health Inc
Experts Providing Healthcare

Accident History Questionnaire

PATIENT INFORMATION

Name ______________________________ **Date** ______________
Address ____
City ________________ **State** __________ **Zip Code** ______________
DOB __________**Age**________ **SS#** ______________**Marital Status** __________
Sex ☐ Male ☐ Female **How did you hear about the office?** ______________
Home Phone ________________ **Work Phone** ________________
Employer ________________ **Occupation** ________________
Have you missed any days at work? ☐ Yes ☐ No **Dates Missed:** ______________
Date of Accident ______________ **Time of Accident** ____________**AM/PM**
Please Describe the accident in your own words:______________________________
____
____
____
Were you the: ☐ **Driver** ☐ **Front Passenger** ☐ **Rear Passenger** ☐ **Pedestrian**

ACCIDENT SITE

Road/Street Name ________________
City/State ____________________
Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other
Visibility: ☐ Poor ☐ Fair ☐ Good ☐ Other_______
Was your vehicle moving? ☐ Yes ☐ No
Speed of you vehicle: ____________**mph**

YOUR VEHICLE

Make and model of your car:______________
Were you wearing a seatbelt? ☐ Yes ☐ No
Were shoulder harnesses worn? ☐ Yes ☐ No
Did the airbag inflate? ☐ Yes ☐ No
Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest?
☐ Top of headrest even with **bottom** of head
☐ Top of headrest even with **top** of head
☐ Top of headrest even with **middle** of neck

OTHER VEHICLE

Make and model other vehicle ____________
Speed of other vehicle ____________**mph**

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No
Did your body strike anything inside the vehicle?
☐ No ☐ Yes, explain____________________
Type of Impact: ☐ Front ☐ Rear ☐ Left
☐ Right ☐ Other __________
How were you sitting before impact?
☐ Head straight forward ☐ Body Straight
☐ Head up/down ☐ Body Rotated right/left
☐ Head turned right/left ☐ Other
Did you see the accident coming? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No
Was your car braking? ☐ Yes ☐ No

ILLUSTRATION OF THE ACCIDENT

PATIENT CONDITON

Were you unconscious after the accident? □ Yes □ No **If yes, for how long?**___________________

Could you move all parts of your body? □ Yes □ No **If no, which parts couldn't you move and why?**____

Were you able to get out of the car and walk unaided? □ Yes □ No, why not? ___________________

Did you get any bleeding cuts? □ Yes □ No **If yes, where?**___________________________________

Did you get any bruises? □ Yes □ No **If yes, where?** ____

Please describe how you felt, 1) immediately after the accident?______________________________

2) Later that day?____

3) The next day?____

TREATMENT

Did you go to the hospital immediately after the accident? □ Yes □ No

How did you get there? □ ambulance □ police □ someone else drove me □ drove own car

When did you go? □ Immediately after the accident □ Next day □ 2 days or more after the accident

Hospital Name: ________________________________ **Name of Doctor :** _________________________

Treatment received: ____

Medications given: ____

X-rays taken: ____

Did you seek any additional treatment? □ Yes □ No **If yes, who did you see?** __________________

Date of visit?__________________ **Treatment received:** _______________________________________

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

□ **Arm/Shoulder pain**	□ **Foot/toe numbness**	□ **Dizziness**
□ **Low back pain**	□ **Neck stiffness**	□ **Ear ringing**
□ **Neck pain**	□ **Headaches**	□ **Memory Loss**
□ **Upper back pain**	□ **Irritability**	□ **Jaw problems**
□ **Chest pain**	□ **Nausea**	□ **Sleep difficulty**
□ **Leg pain**	□ **Stomach upset**	□ **Blurred vision**
□ **Hand/finger numbness**	□ **Chest pain**	□ **Shortness of breath**

Past health history: Place an x if it applies and describe:

□ None related to current complaints	□ Hospitalized	□ Surgery
□ Other auto accident(s)	□ Work Accident	□ Illness

Describe condition and treatment:____

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please circle the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?

1. High Blood Pressure (hypertension) □ Yes □ No
2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
3. Diabetes □ Yes □ No
4. Heart or blood vessel diseases □ Yes □ No
5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
7. Have any of your relatives suffered a stroke? □ Yes □ No
8. Were you ever a smoker? If yes, from ___________ to _________________ □ Yes □ No
9. Do you take any medications on a regular basis? □ Yes □ No
    - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)

      ____
10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
    - If yes, from ________________________ to _________________________

- Have you ever had any of the following, even short, temporary attacks, in the last year?

11. Blurred Vision □ Yes □ No
12. Double Vision □ Yes □ No
13. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
14. Complete loss of vision in one or both eyes? □ Yes □ No
15. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
16. Hearing loss in one or both ears? □ Yes □ No
17. Slurred speech or other speech problems? □ Yes □ No
18. Difficulty swallowing? □ Yes □ No
19. Dizziness? □ Yes □ No
20. Temporary lack of understanding? □ Yes □ No
21. Loss on consciousness, even momentary blackouts? □ Yes □ No
22. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
23. Any other abnormal sensations in any part of your body? □ Yes □ No
24. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
25. Sudden collapse without loss of consciousness? □ Yes □ No

Patient Signature ____ Date ______________________

PATIENT DESCRIPTION OF AUTOMOBILE ACCIDENT

Patient Name: ________________________________ Date:______________

Explain in your own words exactly how this accident occurred: what you felt as it happened, and how have you felt since. It is important that you describe all activities related to this accident including any emergency help such as paramedics, police, bystanders etc. that may have assisted.

DTC Location
5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
303.577.9977

AUTO INJURY, WOMRKMAN'S COMPENSATION AND PERSONAL INJURY

Patient Name: ______________________________________ **DOB:**______________________

Claim Number: _____________________________________ **Date of Injury:** ______________

Insurance Company Name: ____

Phone Number: ____

Adjustor's Name: ____

Adj. Direct Phone Line or Extension: ____

Insurance Billing Address:____

Insurance Fax: ____

Medpay: ☐ **Yes** ☐ **No** **If Yes, Medpay in the amount of: $**_________________

Attorney's Law Firm: ____

Attorney's Contact Name: ____

Attorney Phone: ______________________________ **Attorney Fax:** ______________________

Employer: **(if Workman's Compensation)**

____

Referring Doctor's Name: ____________________ **Doctor's Phone:** ____________________

I certify that the information provided to Integrative Health is correct and up to date to the best of my knowledge. If any of the provided information shall change, Integrative Health is be provided with an updated form.

Patient Signature: ______________________________________ **Date:**______________________

HEALTHCARE PROVIDERS LIEN

Covers all Health Care Providers seen at Integrative Health, Inc.

Patient/Client Name: ____

Insurance Company:____

Date of Injury:____

Claim #:____

Upon receiving proceeds on my behalf, I hereby authorize and direct my attorneys, to pay directly to the referenced Healthcare Provider(s) such sums from any settlement, judgment or verdict from my personal injury claim based on the injury reference above, to fully compensate said Healthcare Provider(s) for charges and services rendered on my behalf. This lien applies to sums currently owed and to sums which may be incurred in the future, and said lien applies against any proceeds of any settlement, judgment or verdict regarding the personal injury claim which may be paid to my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the above-reference provider(s) for all professional bills submitted by them for the services rendered to me. This agreement is made solely for said Healthcare Providers' protection and in consideration of awaiting payment. I understand that payment for healthcare services is not contingent on any settlement, judgment, etc. I am obligated to pay all bills regardless of the outcome of my personal injury claim.

Dated: ____________________ Client Signature:________________________________

The above referenced Healthcare Provider(s) agrees that in exchange for execution of this lien by the patient, and patient's attorney, the provider(s) will refrain from referring any bills for professional services rendered to the patient to any third party for collection or take any legal action to collect these bills until the personal injury claim is resolved. The amount owed, subject to this lien is the current balance at the time the claim is settled.

Dated: ____________________ Client Signature:________________________________

ATTORNEY'S OFFICE

The undersigned attorney for the above patient hereby agrees to observe the above terms and agrees to withhold any such sums from any settlement, judgment, or verdict and pay such sums directly to the Healthcare Provider(s). Attorney agrees to contact the Healthcare Provider(s) before the disbursement of recovery to determine the current account balance.

Dated: ____________________ **Attorney's Signature:**________________________________

5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

________ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

________ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

________ (initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

________ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

________ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

________ (initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

________ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

____
Your Printed Name

____ _____________
Signature Date

5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

____

Your Printed Name

____ ____________

Signature Date