FRALICK CHIROPRACTIC

CAD INJURY HISTORY FORM

ATTORNEY INFORMATION

Name: _____ Email: _____
Phone: _____ Fax: _____
Address: _____

GENERAL INFORMATION

Patient Name: _____ Today's date: _____ Date of Injury: _____
Were you employed at time of the crash? ☐ Y ☐ N Are you currently employed? ☐ Y ☐ N
If no, is your unemployment status due to the crash? ☐ Y ☐ N
Type of Work: ☐ Office/Clerical ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

INJURY HISTORY

Was the crash on the job? ☐ Y ☐ N
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator
☐ Motorcycle passenger ☐ Other: _____
Vehicle driven by: _____
Your vehicle year/make/model: _____
Your estimated speed at the moment of the crash: ☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle year/make/model: _____
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other: _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable ☐ Up ☐ Down ☐ Don't Know
If adjustable, was the position altered by the crash? ☐ Y ☐ N
Was the seat back adjustment altered by the crash? ☐ Y ☐ N
Was the seat broken? ☐ Y ☐ N Seat belt: ☐ Wearing ☐ Not wearing ☐ Don't Know
Did the air bag deploy? ☐ Y ☐ N If yes, were you struck? ☐ Y ☐ N
Body position: ☐ Good ☐ Forward lean ☐ Other: _____
Head position: ☐ Forward ☐ Left ☐ Right ☐ Up ___
Down Hand position: ☐ One on the wheel ☐ Two on the wheel ☐ N/A
Brakes applied? ☐ Y ☐ N
Were you aware of impending crash? ☐ Y ☐ N

DURING THE CRASH

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe: _____
Did the vehicle strike any objects after impact? ☐ Y ☐ N
If yes, describe: _____
Wearing hat or glasses? ☐ Y ☐ N If yes, were they still on after the crash? ☐ Y ☐ N
Did you lose consciousness? ☐ Y ☐ N If yes, for how long? _____
Estimated property damage to your vehicle: $___
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐ Y ☐ N
If yes, was a report made? ☐ Y ☐ N

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AFTER THE CRASH

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain
☐ Parasthesia(s) If yes, where? _____
Extremity pain? If yes, where? _____ Back pain? ☐ Y ☐ N
When did symptoms first appear? _____
Immediately (describe which symptom & how many hours afterward) _____
Where did you go after the crash? ☐ Home ☐ Work ☐ Hospital
Mode of transportation: _____

Crash Details:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMERGENCY DEPARTMENT

Radiographs: Y N Body parts imaged:
Results: _____
Lab work ◯ Y ◯ N Cervical collar ◯ Y ◯ N Ice ◯ Y ◯ N

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Medications: _____

Other : _____

Follow up instructions: ☐ Y ☐ N If yes, explain _____

Have you had any prior treatment for the injuries sustained in this crash (ie. ER, family physician, physio) ☐ Y ☐ N

PAST MEDICAL HISTORY

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals: _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal Injuries (date, TX, awards, residuals): _____

Sports or other injuries to head, neck, or back: _____

Our Promise is that we will personally do everything within our power to relieve you of your symptoms in a treatment plan that is uniquely personalized to fit your medical needs. In doing so, our approach will lead to your recovery utilizing techniques that are both precise and thorough; Optimizing the likelihood of achieving 100% relief of symptoms. We further promise to suppress our egos and never allow them to get in the way of your full recovery; With that and when clinically necessary, We will choose to co-treat with as many medical professionals as needed to provide you with the absolute "medical action plan" possible and further ensure the highest quality of clinical care.

Dr. Fralick and his team specialize in Acute care for a wide variety of injuries and ailments. With Dr. Fralick holding multiple degrees (see curriculum vitae under his personal profile) he is able to treat every joint in the body from head to toe. Our goal is to provide you with the absolute best personalized, patient centered care that fits not only your lifestyle but also your unique injury. We know that all injuries are unique to the individual.
Therefore each case is treated as such and each patient diagnosis is given the time, care, and attention to detail it needs and you expect.

We have created a professional network of medical practioners and legal consultants whose expertise will help manage any/all complex cases where clinical care and other expertise is 100% patient centered resulting in optimal outcomes!

- Dr. Ryan Fralick

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By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please feel free to ask a member or our front office staff.

Patient and Insurance Information Date:

Name: _____ DOB: _____ SSN: _____
Address: _____
City: _____ State: _____ ZIP: _____

Home #: _____ Work #: _____ Cell #: _____
Email : _____ Email Appointment Reminders ☐ Yes ☐ No

Driver's License # (if balance placed on a lien): _____ State: _____
Employer: _____ Occupation: _____
Student: Full Time_____ Part Time _____
Referral: _____
Primary Care Physician: _____
In Case of Emergency Contact: Name _____ Phone # _____

Health Insurance Information

Carrier: _____
Address: _____ City: _____ State: _____
Identification #: _____ Group: _____
Insurance #: _____ Patient Relationship to the Insured: Self Spouse Child Other
***If you are not the guarantor (self), please complete:
Name of Insured: _____ DOB: _____
Address of Insured: _____ City: _____ State: _____
Phone of Insured: _____

Auto Accident Insurance (Medical Payment)

Carrier: _____
Policy #: _____ Claim # _____
Name of Adjuster: _____ Phone #: _____
Date of Injury: _____
Patient relationship to the insured: Self Spouse Child Other

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED ANDDISCLOSED AND HOW

YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as judicial proceedings. We may contact a family member or other authorized person in consent unless compelled to do so by legal authority. Further, you will be contacted by phone or mail in the event that a request for information is made.

FACILITY SET UP

While our examination and treatment rooms are private, this office utilizes an open exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosures to others in the facility at the same time. If there is private information that you need to discuss, please request to do so in a private room.

YOUR RIGHTS

You may send us a written request to see or procure a copy of the information that we have about you, or to amend you personal information that you believe is incomplete or inaccurate. If the information was not originally from our office, we will refer you to the source, such as other doctors or hospitals.

You may request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances, may be prohibited by law.

You may request that we communicate with you about medical matters using reasonable alternative means or at an alternate address.

You may receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

You have the right to inspect and have a copy of your medical information. There is no cost for the first copy and any copy thereafter will be $25.

You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is a disagreement, you will be provided with information about your denial of your amendment and how you may appeal the denial of amendment. You have a right to a copy of the notice upon request.

COMPLAINTS

Calling this office or directing a letter to the office manager can handle complaints about your privacy rights or how your privacy is handled at this office. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights) 200 Independence Ave Room 509F HHH Building Washington, D.C. 20201

I have read this privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

_____	_____	_____
Patient's Name (Print)	Patient's Signature	Date

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CHIROPRACTIC CASE HISTORY

Date _____ Name _____ M ◯ F ◯ Date of Birth _____

Have you ever received Chiropractic Care? Y ◯ N ◯ If Yes, when? _____

Were you injured in an automobile collision? Y ◯ N ◯

If yes, what was the date of your accident? _____

Referred by: _____

1. Primary reasons for seeking chiropractic care

Primary Reason: _____

_____

Secondary Reason/Contributing Factors: _____

Location of Complaint _____

When and how did the complaint begin? _____

_____

Please select the quality of the complaint/pain: Dull aching ◯ Sharp ◯ Shooting ◯ Burning
Throbbing ◯ Deep ◯ Nagging Other, please describe: _____

Does this complaint/pain travel (shoot) to any areas of your body? Y ◯ N ◯

Where

Grade Intensity (no complaint/pain) 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ (worst possible / imaginable)

How frequent is complaint present? _____ How long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatment, medications, surgery, or care you have sought for your complaint?

_____

_____

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Past Health History

Previous illnesses you have had? _____

Previous injury or trauma: _____

_____

Have you ever broken any bones? _____

_____

Allergies: _____

Medications	Reason for taking
_____	_____
_____	_____

Surgeries/Date:	Types of Surgery
_____	_____
_____	_____

Females/Pregnancies and Outcome(s):

_____

_____

Family Health History

Associated health problems _____

_____

Social and Occupational History:

Job Description _____

Work Schedule: _____

Recreational Activities: _____

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Lifestyle, hobbies,level of exercise, diet, alcohol, tobacco and drug use:

_____

_____

_____

I have read the information above and certify it to be true and correct to the best of my knowledge, and hereby authorize Fralick Chiropractic to provide me with chiropractic care, in accordance with the State of Pennsylvania's statutes.

Patient Signature _____ Date _____

Patient or Guardian Signature _____ Date _____

Assignment of Benefits

I hereby assign payment directly to Fralick Chriropractic who represents this clinic to Payer Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles, co-insurance or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information in writing to Fralick Chiropractic as soon as any changes occur in my insurance coverage or address.

Signature _____ Date _____

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Release of Information

I **do/do not** (please circle one) authorize _____ (physicians name) to release any of my medical records, x-rays, or reports to Fralick Chiropractic for the purpose of obtaining medical information pertaining to my treatment.

Signature _____ Date _____

Authorization to Discuss PHI

If you would like your Personal Health Information (PHI) to be discussed or given to another person, please give the name of that person below and sign, giving us permission to discuss your PHI with them.

Print Name: _____

Patient Signature: _____ Date: _____

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