Denver Integrated Spine Center
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Patient Information

Today's Date_____

Name_____Date of Birth _____Date of Accident_____

Address_____City/State_____Zip_____

Home Phone _____Cell Phone_____

Work Phone_____Email Address_____

Gender_____Marital Status_____

Nearest relative not living with you_____phone #_____

Emergency Contact_____phone #_____

Your Auto Insurance

InsuranceCompany_____Policy#_____

Insured's Name_____MedPay Claim#_____

Adjustor's Name_____Phone#_____

At-Fault Auto Insurance

Insurance Company_____Policy#_____

Insured's Name _____Claim #_____

Adjustor's Name_____Phone#_____

Our Privacy Policy

The office of Denver Integrated Spine Center is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Denver Integrates Spine Center, LLC may be forwarded to referring physicians, specialists, or therapist who are also involved in my healthcare.

Consent for Release of Information

☐ By checking this box, I agree to be contacted and that voicemail may be left on my phone by Denver Integrated Spine Center patient liaison or Physician.

CONSENT FOR THE TRANSMISSION OF INFORMATION: By checking this box, I give Denver Integrated, permission to communicate any future medical information to me by the telephone and/or email provided earlier in this document.

Regarding Your Healing

1. Auto injuries produce wide spread damage and thus take more visits then an average case of non-auto related acute neck or back pain. Everyone responds to treatment slightly different which may shorten or lengthen the amount of total visits needed.
2. Neck or back pain usually fluctuates, meaning that you will have flare ups along the course of your healing. It is expected to have aggravations of your injuries.
3. If you have never been adjusted, you may be sore after your treatment. This soreness is similar to a long hike or a good workout type of soreness. Soreness can be a good response, as is the soreness you get after a good workout.

By signing below, I understand this agreement to be between Denver Integrated Spine Center and THE UNDERSIGNED.

Signature _____Date_____

History of Accident

Date of accident _____Time of accident_____

Location of accident City/State_____Street/s_____

Which police department responded to your accident? _____

Where were you sitting when the accident occurred? Driver ___Front Seat Passenger _____Other_____

If you were not driving, who was? _____ Were you wearing your Seat Belt? _____

Accident type? Rear ended _____Head on _____Broad-sided _____Other_____

Weather conditions? Clear _____Raining _____Snowing _____Foggy_____

Road conditions? Dry _____Wet _____Icy_____

Year/Make/Model of your vehicle _____Other vehicle_____

Your approx. speed at impact? _____Other vehicle_____

Body position at time of impact? Good _____Forward leaning _____Other_____

Your head position at impact? (forward/turned left/right/ up/down) _____

Where was headrest located before impact? __Upper back __Mid neck __Mid head __Upper head __None

Where were your hands? 1 on wheel_____2 on wheel_____ Were you aware of Impending Impact? _____

Were you wearing a hat or sunglasses? _____ Were they still on after the accident? _____

Drivers Feet Position at Impact? (brake, clutch, both, gas, etc.) _____

Did you strike any parts of the vehicle's interior? _____Please describe_____

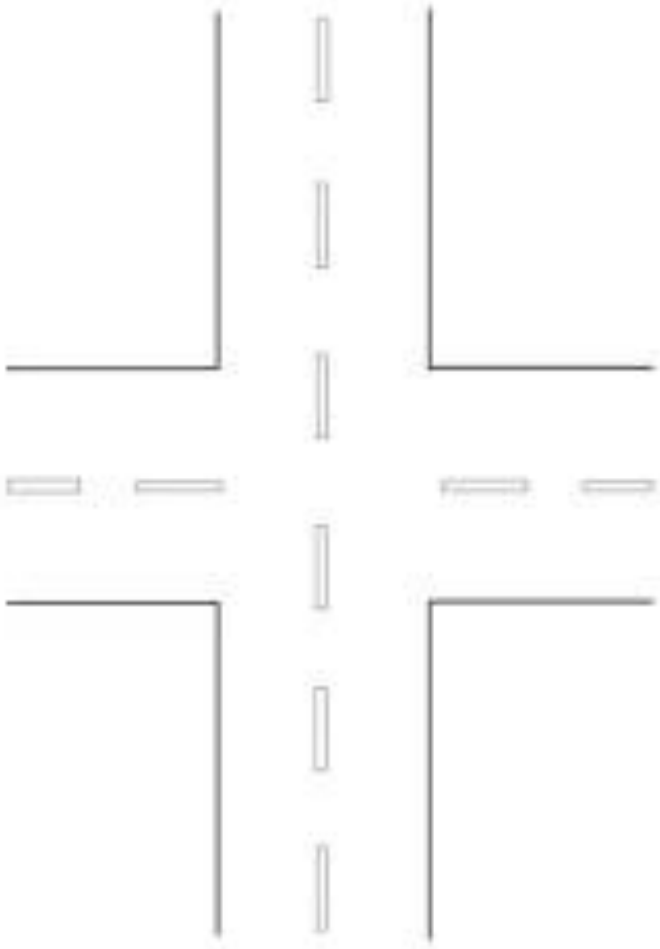
Did your car hit anything else after the initial impact? ____ Please describe_____

Did you lose consciousness? _____ If so, how long were you unconscious? _____

Did your airbags deploy? _____Did your seat break? _____

What Part of your car was damaged?_____Their's_____ Cost of repairing your car_____

Describe the Accident



Injuries, Impairments, & Damages

Please mark any of the symptoms you have experienced SINCE the accident

__Headaches __Dizziness __Difficulty Concentrating

__Long Term Memory Loss __Short Term Memory Loss __Amnesia

__Loss of Consciousness at Scene __ "Blackouts" Since Collision __Forgetting ATM or other Numbers

__Reading Problems __Writing Problems __Typing Problems

__Apathy __Irritability __Sleep Disturbances

__Personality Changes __Emotional Difficulties __Relationship Difficulties

__Blurred Vision __Photophobia (Sensitivity to Light) __Vision Changes

__Intolerance to Alcohol __Intolerance to Heat __Intolerance to Cold

__Impaired Comprehension __Impaired Learning __Attention Impairment

__Loss of Libido __Missing Periods of Time __Speech Difficulties

__Concussion in Collision __Nausea __Vomiting

__Extreme Thirst Since Collision __Fatigue __Menstrual Irregularities

__Tinnitus (Ringing of Ears) __Noise Intolerance __Loss of Coordination

__Bumping Into Objects in View __Loss of Balance __Fluid in Ears

__Hearing Loss __Vertigo (Spinning Sensation) __Increased Symptoms in Crowds

__Anxiety __Depression __Change in Personality

__Flashbacks to Accident Scene __Intrusive Thoughts of Accident __Nightmares Since Collision

__Unusual Behavior Since Collision __Social Withdrawal __Panic Attacks

__Thoughts of Death /Suicide __Weight Loss / Gain _____lbs. __Loss of Taste / Smell

__Blackouts with Neck Movements __Dizziness with Neck Movements __ "Clunk" Sound w/ Moving Neck

__Jaw Pain __Clicking in Jaw __Pain with Chewing Numbness / tingling / weakness in arms? Yes No R L

Numbness / tingling / weakness in legs? Yes No R L

Did the Seatbelt bruise you? _____Where? _____

Injuries, Impairments, & Damages Cont.

Were you transported via EMS or Ambulance? ___ Yes ___ No (If yes, please provide)

Name of Ambulance Company Date From To

1._____

Please list any Emergency Room, Urgent Care, Hospitalizations, Outpatient Surgeries (Related only to this Collision):

Physician Facility Surgery / Problem

1._____ 2. _____

3._____ 4. _____

Please list any Treating Physicians / Specialists / Therapists (Related only to this Collision):

Provider Facility Address Phone

1._____

2._____

3._____

Impaired Activities

Circle all activities which have been impaired in any way by the accident in question:

Daily Activities

bathing/showering	bending	brushing teeth	dressing	driving car
vacationing	dining out	movie going	standing	sitting
sexual relations	lifting	church events	childcare	religious (bending/kneeling)
washing hair	eating	moving	reading	shaving
shopping	watching TV	sleeping	traveling	social events

Domestic Activities (Activities within the Home)

Housecleaning	cooking	ironing	laundry	decorating washing
Dishes	vacuuming	dusting	interior painting	

Household Activities (Activities outside the Home)

trimming bushes	gardening	tree trimming	mowing Lawn	yard work
exterior painting	car washing	landscaping	house maintenance	farm activities

Work Activities

sitting	standing	lifting	using telephone	computer work
reading	bending	typing	writing	childcare

Hobby Activities

aerobic exercise	archery	backpacking	bowling	badminton
baseball	basketball	basketry	bicycling	boxing
card playing	camping	dancing	fencing	fishing
flying	football	gardening	golf	handball
gymnastics	health clubs	hockey	hunting	judo
horseback riding	ice skating	Karate	painting	yoga
jogging/running	photography	racquetball	rafting	sailing
mountain climbing	sewing	snow skiing	swimming	walking
musical instruments	volleyball	water skiing	water sports	weightlifting

Activities which you have performed despite pain, due to financial, family or personal needs (Duties Under Duress):__Work __Education __Domestic (Activities within the Home) __Household (Duties outside the Home)

_____

Past Motor Vehicle Accidents, Workers Compensation Claims, or other claims of Any Sort: _____

_____

_____

Injuries, Impairments, & Damages Cont.

Describe your Headache pain: ___ Sharp ___ Dull ___ Aching ___ Stabbing ___ Cramping

Are your symptoms (please check): _____Constant ____Come and go

Onset: Did the headaches start? ___ Before accident ___ At time of accident ___After accident

How severe are your headaches on a scale of 1 to 10? _____ (1 is no pain – 10 is the worst pain you have ever experienced)

What makes your headaches worse? __Washing __Dressing __Grooming __Lifting __ Sitting __Standing

Describe your Neck pain: ___ Sharp ___ Dull ___ Aching ___ Stabbing ___ Cramping

Are your symptoms (please check): _____Constant ____Come and go

Onset: Did the neck pain start? ___ Before accident ___ At time of accident ___After accident

How severe are your neck pain on a scale of 1 to 10? _____ (1 is no pain – 10 is the worst pain you have ever experienced)

What makes your neck pain worse? __Washing __Dressing __Grooming __Lifting __ Sitting __Standing

Do you experience any numbness, tingling or weakness into your arms? _____

Describe your Back pain: ___ Sharp ___ Dull ___ Aching ___ Stabbing ___ Cramping

Are your symptoms (please check): _____Constant ____Come and go

Onset: Did the back pain start? ___ Before accident ___ At time of accident ___After accident

How severe is your back pain on a scale of 1 to 10? _____ (1 is no pain – 10 is the worst pain you have ever experienced)

What makes your back pain worse? __Washing __Dressing __Grooming __Lifting __ Sitting __Standing

Do you experience any numbness, tingling or weakness into your legs? _____

Describe your Extremity pain: ___ Sharp ___ Dull ___ Aching ___ Stabbing ___ Cramping

Where is it located? L Arm R Arm L Hand R Hand L Leg R Leg L Foot R Foot

Are your symptoms (please check): _____Constant ____Come and go

Onset: Did the extremity pain start? ___ Before accident ___ At time of accident ___After accident

How severe are your extremity pain on a scale of 1 to 10? _____ (1 is no pain – 10 is the worst pain you have ever experienced)

What makes your extremity pain worse? __Washing __Dressing __Grooming __Lifting __ Sitting __Standing

Injuries, Impairments, & Damages Cont.

Describe any cognitive issues you are having and give life examples where appropriate:

Forgetfulness: ___ Yes ___No _____

Confusion: ___ Yes ___No _____

Anxiety: ___ Yes ___No _____

Sadness: ___ Yes ___No _____

Anger: ___ Yes ___No _____

Sleep Disturbance: ___ Yes ___No_____

Suicidal thoughts: ___ Yes ___No _____

Homicidal thoughts: ___ Yes ___No _____

List any medical problems you have: _____

Have you had any major surgeries? ___ Yes ___No (if yes please list surgery and approximate date(s)

_____

List any medications you are currently taking: _____

_____

Do you have any drug allergies? ___ Yes ___No (if yes please list)

_____

Do you have severe illness in your family? (Heart disease, blood clot, diabetes, etc.) ___ Yes ___No

Please List:_____

Do you: use tobacco? ___ Yes ___No -- **Alcohol?** ___ Yes ___No -- **Illicit Drugs?** ___ Yes ___No

Are you currently working? ___ Yes ___No **What is your occupation? _____**

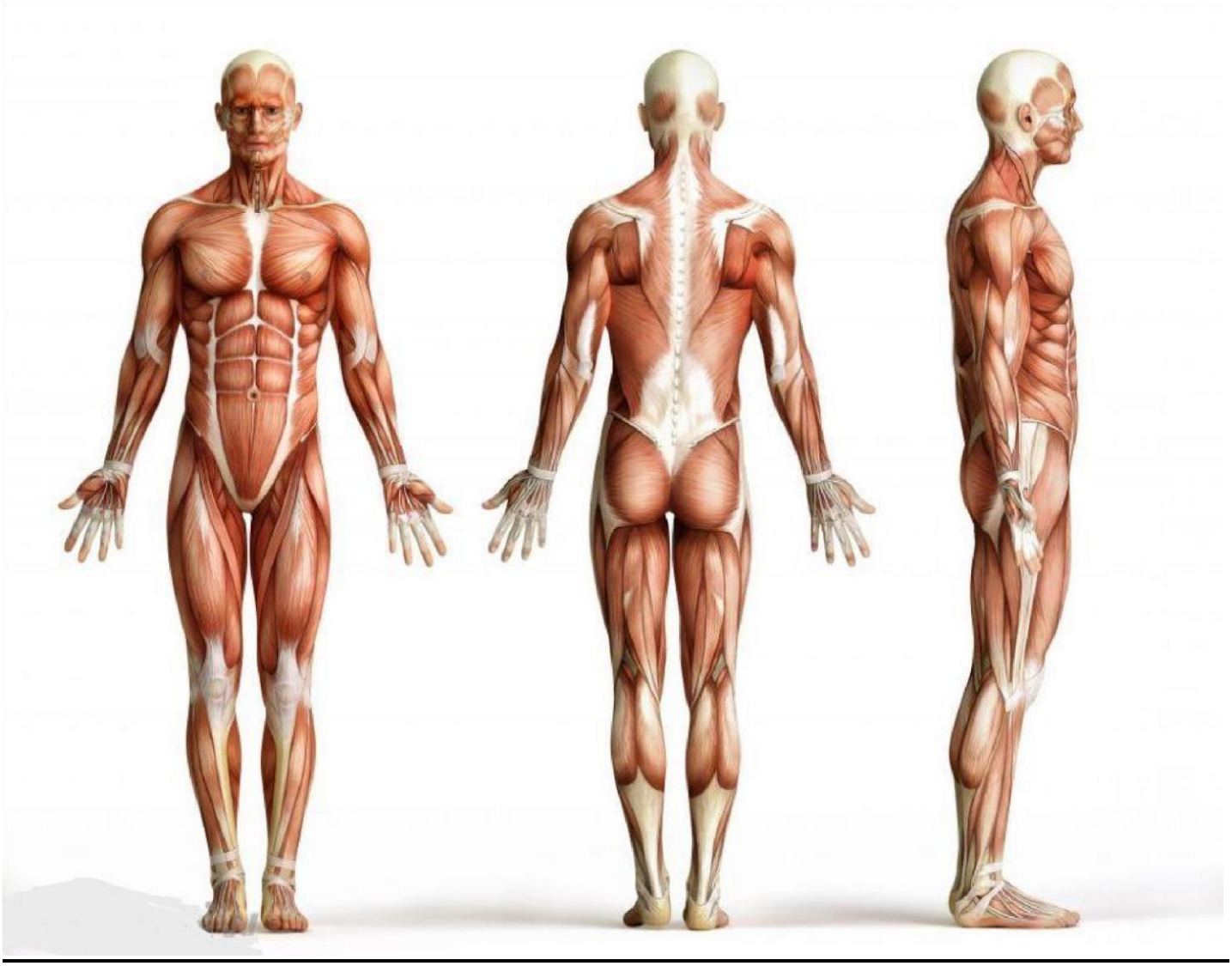
Female patients:

Could you be pregnant? ___ Yes ___No – **Are you breast feeding**? ___ Yes ___No

Injuries, Impairments, & Damages Cont.

Using the diagram, mark the areas you feel pain using the symbols below:

A = ache
B = burning
D = Dull
N = Numbness
P = Pins and needles
S = Stabbing
T = Throbbing



********** OFFICE USE ONLY **********

Vitals: T_____ BP_____/_____ P_____ SaO2_____