# Personal Injury Intake Form

## Patient Information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today’s Date</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>I prefer to be called</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td></td>
</tr>
<tr>
<td>If minor, name of parent or guardian</td>
<td></td>
</tr>
<tr>
<td>Who should we contact in case of an emergency?</td>
<td></td>
</tr>
<tr>
<td>Relation</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Attorney</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td></td>
</tr>
<tr>
<td>How did you hear about our office?</td>
<td></td>
</tr>
</tbody>
</table>

## Health Insurance Information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company</td>
<td></td>
</tr>
<tr>
<td>Policy Holder’s Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

## Auto Insurance Information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

## Accident Information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>Was it reported to the police?</td>
<td></td>
</tr>
<tr>
<td>Was a traffic violation issued?</td>
<td></td>
</tr>
<tr>
<td>Location of accident (Street, Town)</td>
<td></td>
</tr>
<tr>
<td># of other passengers</td>
<td></td>
</tr>
<tr>
<td>Were there other witnesses?</td>
<td></td>
</tr>
<tr>
<td>Make/model of vehicle you were in</td>
<td></td>
</tr>
<tr>
<td>Please explain in detail how the accident occurred</td>
<td></td>
</tr>
<tr>
<td>Please list symptoms felt immediately after the accident</td>
<td></td>
</tr>
<tr>
<td>In which direction were you headed?</td>
<td></td>
</tr>
<tr>
<td>Approx. speed of vehicle</td>
<td></td>
</tr>
</tbody>
</table>

Do you have med pay? **Y** / **N**  
Do you have uninsured motorist? **Y** / **N**
Did the impact to your vehicle come from the:  FRONT  REAR  RIGHT  LEFT  OTHER
During impact, were you facing:  RIGHT  LEFT  FORWARD
Were you AWARE or SURPRISED by the impact?
Were you the  DRIVER  FRONT SEAT PASSENGER  BACK SEAT PASSENGER?
Were you wearing a seat belt?  SHOULDER HARNESS  LAP HARNESS
Was the vehicle equipped with air bags?  YES  NO  Did they inflate?  YES  NO
In relation to the base of your skull, where was the headrest?  ABOVE  BELOW  AT BASE
What did your vehicle impact?  ANOTHER VEHICLE  OTHER
If another vehicle, what was the make/model?             Direction    Speed    MPH
Did any part of your body strike anything in the vehicle?  YES  NO  Describe ______________________________
Did the accident render you unconscious?  YES  NO  If yes, for how long?  ________________

Post-Injury Information:
Have you seen any other doctor(s) since the accident?  YES  NO  Name ______________________________
When did you go?  IMMEDIATELY  NEXT DAY  2 DAYS PLUS
How did you get there?  AMBULANCE  PRIVATE TRANSPORTATION
Name of hospital and/or attending doctor: ______________________________
Was he/she a:  D.C.  M.D.  D.O.  D.D.S.  
Please describe any treatment you received
Were X-Rays done?  YES  NO  An MRI?  YES  NO  CAT scan?  YES  NO
Was medication prescribed?  YES  NO  If yes, what?  ______________________________
Have you missed any work since the accident?  YES  NO  Date(s) ______________________________
Are your work activities restricted as a result of your injury?  YES  NO
Have you been unable to perform certain tasks, hobbies, etc. since the accident such as (exercise, running, aerobics, swimming, hiking, driving, etc)? Do you consider your self an athletic individual?  Y  or  N

Answer the above questions and check off symptoms on page 4 as well
Did you ever experience similar symptoms prior to the accident?  YES  NO
Has your condition  IMPROVED  WORSENED  or  STAYED SAME  since the accident?
Is your condition affecting your  WORK  SLEEP  or  DAILY ROUTINE?  Please explain _______

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

____ Lying on Back  ____ Lying on Side  ____ Lying on stomach  ____ Sitting
____ Standing  ____ Stretching  ____ Lovemaking  ____ Walking
____ Running  ____ Sports  ____ Working  ____ Lifting
____ Bending  ____ Kneeling  ____ Pulling  ____ Reaching

Approximately how much damage was done to your car?  $_________________________
How many hours are in your normal workday? __________

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

<table>
<thead>
<tr>
<th>STANDING</th>
<th>OPERATING EQUIPMENT</th>
<th>DRIVING</th>
<th>SITTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>TWISTING</td>
<td>WORK W/ARMS ABOVE HEAD</td>
<td>WALKING</td>
<td>CRAWLING</td>
</tr>
<tr>
<td>TYPING</td>
<td>LIFTING</td>
<td>BENDING</td>
<td>STOOPING</td>
</tr>
</tbody>
</table>

What positions can you work in with minimum physical effort, and for how long? ________________

Do you work with others who can help you with any heavy lifting?    YES       NO

While in recovery, are there any light duty tasks you could request?    YES       NO

Health History

Have you ever had any of the following diseases or conditions?

HEART ATTACK or STROKE               HEART SURGERY or PACEMAKER   HEART MURMUR
CONGENITAL HEART DEFECT               MITRAL VALVE COLLAPSE         ARTIFICIAL VALVES
ALCOHOL/DRUG ABUSE                    VENEREAL DISEASE               HEPATITIS
HIV+/AIDS                              SHINGLES                       CANCER
FREQUENT NECK PAIN                     EMPHYSEMA                      ANEMIA
HIGH/LOW BLOOD PRESSURE                PSYCHIATRIC PROBLEMS          RHEUMATIC FEVER
SEVERE/FREQ. HEADACHES                 KIDNEY PROBLEMS               ULCERS/COLOMISIS
FAINTING/SEIZURE/EPILEPSY              SINUS PROBLEMS                 ASTHMA
DIABETES                               DIFFICULTY BREATHING           TUBERCULOSIS
LOWER BACK PROBLEMS                   ARTIFICIAL BONES/JOINTS        ARTHRITIS

Please list any other medical conditions that you have or have ever had. ________________________________

Please list any allergies. _______________________________________________________________________

Please list previous surgeries and dates. ___________________________________________________________

Please list any past motor vehicle accidents or traumas and dates. _____________________________________

Is there anything else about your health history or family health history that you feel is important to share? __________________________________________________________

Do you exercise?    YES       NO

Do you smoke?    YES       NO How much? __________ How long? __________

For women: Are you taking birth control?    YES       NO
Are you pregnant?    YES       NO How long? _______ Nursing?    YES       NO

Patient/Legal Guardian Signature ____________________________ Date ____________________

PBFC&SM Form 2a
### Symptoms

**Patient ___________________________  Date ___________ Date of Injury ___________

**Signature ___________________________

*Please fill in all symptoms you currently have that you did not have before the accident.*

#### Orthopedic & Musculoskeletal Symptoms

- [ ] “Clunk” Sound with Neck Movements
- [ ] Neck Pain
- [ ] Upper Back Pain
- [ ] Low Back Pain
- [ ] Shoulder Pain  [ ] Left  [ ] Right
- [ ] Upper Arm Pain  [ ] Left  [ ] Right
- [ ] Elbow Pain  [ ] Left  [ ] Right
- [ ] Forearm Pain  [ ] Left  [ ] Right
- [ ] Wrist Pain  [ ] Left  [ ] Right
- [ ] Hand Pain  [ ] Left  [ ] Right
- [ ] Hip Pain  [ ] Left  [ ] Right
- [ ] Upper Leg Pain  [ ] Left  [ ] Right
- [ ] Knee Pain  [ ] Left  [ ] Right
- [ ] Lower Leg Pain  [ ] Left  [ ] Right
- [ ] Ankle Pain  [ ] Left  [ ] Right
- [ ] Foot Pain  [ ] Left  [ ] Right
- [ ] Jaw Pain
- [ ] Clicking in Jaw
- [ ] Pain when Chewing
- [ ] Face Pain
- [ ] Chest Pain
- [ ] Stomach Pain
- [ ] Bruise/Contusion to __________________
- [ ] Abrasion/Scrape to __________________
- [ ] Other Symptom _____________________
- [ ] Other Symptom _____________________

#### Neurological Symptoms

- [ ] Numb/Tingling Arm / Hand  L  R
- [ ] Numb/Tingling Leg / Foot  L  R
- [ ] Weakness Arm / Hand  L  R
- [ ] Weakness Leg / Foot  L  R

#### Brain/Neuropsych/MTBI Symptoms

- [ ] Wanting to be Alone
- [ ] Sleepiness
- [ ] Nausea/vomiting
- [ ] Difficulty Concentrating
- [ ] Day Dreaming/Staring Mindless Staring
- [ ] Mood Swings
- [ ] Agitation
- [ ] Sadness or tearful
- [ ] Blurry Vision
- [ ] Double Vision
- [ ] Disoriented
- [ ] Confused
- [ ] Difficulty Speaking
- [ ] Feelings of Isolation from Others
- [ ] Attention Problems
- [ ] Appetite Change
- [ ] Pupils Different Sizes
- [ ] Room Spins/ Woozy Feeling
- [ ] Balance Problems
- [ ] Difficulty Walking
- [ ] Difficulty Focusing/Easily Distracted
- [ ] Very Tired
- [ ] Dozing During The Day
- [ ] Personality Change
- [ ] Can’t Remember Numbers
- [ ] Reading Problems
- [ ] Writing Problems
- [ ] Difficulty with Adding/Subtracting
- [ ] Poor Attention
- [ ] Difficulty Learning New Things
- [ ] Difficulty Understanding
- [ ] Difficulty Remembering Things
- [ ] Re-reading Things to Understand It
- [ ] Anger
- [ ] Difficulty Making Decisions
- [ ] Change in Sexual Functioning
- [ ] Reduced Confidence
- [ ] Helplessness
- [ ] Apathy (Don’t Care)
- [ ] Irritable
- [ ] Change in Sense of Taste or Smell
- [ ] Flashbacks to Accident
- [ ] Impatience
- [ ] Frustration
- [ ] Hearing Problems
- [ ] Difficulty Planning or Organizing

#### Symptoms Associated with Injuries

- [ ] Range of Motion Problems
- [ ] Headaches
- [ ] Muscle Spasms
- [ ] Dizziness
- [ ] Visual Disturbances
- [ ] Sleep Disruption
- [ ] Radiating Pain
- [ ] Anxiety
- [ ] Depression
- [ ] I am taking over-the-counter pain meds
- [ ] Patient ___________________________
- [ ] Date ___________ Date of Injury ___________ 

**Signature ___________________________
FORMAL NOTICE OF MEDICAL PROVIDER LIEN
PATIENT/CLAIMANT AUTHORIZATION AND DIRECTIVE
TO INSURANCE CLAIM ADJUSTER

To:_________________________ Date:_________________________
_________________________ Via Certified Mail #:_____________
_________________________ RE: _____________________________
_________________________ Claim # ___________________________
Insured: __________________ Policy # _______________________
Date of Accident:_________________ Lien office: Hashimoto Chiropractic Inc
                                          47875 Caleo Bay Dr, Ste A104
                                          La Quinta, CA 92253

To whom it may concern:

You are hereby notified that the above party sought medical care from our medical center for those injuries he/she sustained in the above dated auto accident.

This patient has stated that liability for the accident rests with your insured and company. As the patient has no other source of personal insurance, he/she was requested to sign the attached medical lien contract/agreement. Through this the patient has committed assurance that necessary and provided treatment and care from Hashimoto Chiropractic Inc, would be paid from proceeds of his/her above identified injury claim against your carrier.

In accordance with terms and provisions of the Statue of the State of California, in such case made and provided; this lien is submitted to you, with notice of intention to provide the claimant such necessary medical services. The below signature Authorizes and Directs

AT TIME OF SETTLEMENT OR MEDICAL BILL PAYMENT,

HASHIMOTO CHIROPRACTIC INC, SHALL BE NAMED AS CO-PAYEE ON ANY DRAFT ISSUED TO THE ABOVE CLAIMANT

Please file and post this document in your file computer index, so it may be recorded and any new adjuster shall have proper notice. Please write/call our office should you have any questions. Return USPO certified mail acknowledgement will be maintained as our record.

_________________________  _______________________
Patient/Claimant Signature        Date

Enclosure: Medical Lien
NOTICE TO MY ATTORNEY OF DOCTOR LIEN
For the Office of N2Health – Chiropractic & Acupuncture
47875 Caleo Bay Dr Ste A104, La Quinta, CA 92253
PH: (760) 777-8377 FAX: 760-777-9377

I hereby authorize Drs. Coleman and/or Hashimoto and/or N2Health to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about __________________________, for which you have been retained.

I understand that all bills incurred by me at Drs. Coleman and/or Hashimoto’s office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with Drs. Coleman and/or Hashimoto. I also understand that, unlike my attorney, Drs. Coleman and/or Hashimoto does not work on a contingency fee and I must pay for his services at the time of his rendering of them and that this lien is only to protect his interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed Drs. Coleman and/or Hashimoto for my health care in connection with this accident and pay it directly and promptly to Drs. Coleman and/or Hashimoto at:

N2Health – Chiropractic & Acupuncture
47875 Caleo Bay Dr, Ste A104
La Quinta, CA 92253

I am granting Drs. Coleman and/or Hashimoto an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case.

_____________________________      ____________________________   __________
Print Name                  Patient’s Signature                  Date

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

_____________________________      ____________________________   __________
Print Name of Attorney                  Attorney’s Signature                  Date
INFORMED CONSENT
TO CHIROPRACTIC & ACUPUNCTURE CARE

I hereby consent and request the performance of chiropractic and acupuncture procedures, including adjustments, examination tests, diagnostic x-rays, physiotherapy, acupuncture, laser, massage, Chinese herbal medicine and nutritional supplements for the purpose of treatment, on me or for whom I am legally responsible, by the clinical staff at N2Health.

I have been informed that chiropractic and acupuncture are generally safe methods of treatment, but that, as with any health care procedure, there may be certain complications or side effects. Side effects include soreness, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, organ puncture, and burns. The herbs and nutritional supplements (which are from plant, animal and mineral sources) are traditionally considered safe, although possible side effects of the taking the herbs including abdominal discomfort may occur. The clinic uses sterile disposable needles and maintains a clean and safe environment. I will notify a staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

If You Want To Share Your Success Story….

We have many success stories in our office and often patients wish to share these stories with other people. If you would like to share your story with others please read below. These are used to decorate the walls of our office and you voluntarily give it to us.

I hereby grant you, N2Health – Chiropractic & Acupuncture all rights with this my irrevocable explicit approval to use my likeness, voice, etc., as captured or edited, recorded and rendered in various audio, visual, and written medium, to be used in commercial, instructional, and promotional activities as N2Health - Chiropractic & Acupuncture see fit. N2Health - Chiropractic & Acupuncture shall own 100% rights, title and interest in resulting product.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and publicity release agreement. I have been told about the risks and benefits of chiropractic and acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Patient __________________________  Date __________________

Signature of Patient, Parent, or Guardian __________________________________________________________________________________________

47875 Caleo Bay Dr Ste A104, La Quinta, CA  92253  P:  760-777-8377  F:  760-777-9377
Welcome to N2Health – Chiropractic & Acupuncture. We want your experience here to be as pleasant as possible. Please ask the staff or doctor if you have any questions. To acquaint you with our payment arrangements please review the following and sign in acknowledgement.

1. **No insurance:** Unless other arrangements are made with the billing manager, payment is expected at the time services are rendered. We accept personal checks, cash, Visa, or MasterCard.

2. **Group Health Insurance:** We will bill your insurance claims for you. However, we ask that you remember the following: insurance is an agreement between yourself and the insurance company. Any balance beyond what the insurance covers is your responsibility. We will contact your insurance company to verify eligibility and coverage, but we are not responsible for any misinformation that the insurance company may give us. Most insurance plans require you make a co-payment, co-insurance and/or deductible. It is your responsibility to pay these amounts at the time service is rendered unless a specific agreement is made with the billing manager. We are willing to carry the portion owed by your insurance company for 60 days. If your insurance company does not pay their expected amount within 60 days then the charges in full will be collected from the patient. Any unpaid balances beyond 60 days is subject to a 5% service charge per month.

3. **Work Comp:** Work related injuries are managed in conjunction with your employer. Employers carry insurance for this type of injury and they must authorize care and give us the billing information. Most employers will authorize care however, they have medical control for the first thirty days, meaning they can choose who treats you, unless you have a “designated doctor” form on file with the employer previous to your injury. You will not be responsible for your charges unless you elect to treat with us against your employer’s wishes. If you require an attorney to represent you in a contested work related injury case we can recommend several to choose from.

4. **Personal Injury:** We will bill your auto insurance med pay. If you have group insurance we will also bill that for you unless your med pay coverage covers the entire amount of your medical claim. We do not accept group insurance benefits as full payment when there is a third party. If you retain a Personal Injury attorney (approved by this office), we will accept a lien. An approved attorney will fall under the following guidelines: you must formally retain the attorney, attorney must respond to monthly status calls, you and the attorney agree to sign a lien insuring we will be paid from the proceeds of the settlement. If you need a referral to an attorney, please ask and we will provide a list of attorneys that specialize in personal injury cases. Ultimately, you are responsible for the total amount of the bill, the terms are explained in the lien agreement that you and your attorney are required to sign. We reserve the right to cancel the lien agreement at any time. In any case, once you are released from care we will wait only six months for payment. We reserve the right to charge a 5% service charge per month on the unpaid balance until settlement.

5. **Medicare:** I understand that my Medicare insurance policy covers 80% for spinal manipulation only. It does NOT cover examinations, radiographs (x-rays), or modalities. Therefore, I agree to be personally responsible for all non-covered services. I understand that this office must perform an initial evaluation in order to render manipulation under the Medicare agreement. I also understand that I am responsible for a yearly deductible and a co-insurance amount for covered services at the time those services are rendered.

6. **Missed Appointments/Cancellations:** We require 24 hours notice for missed or cancelled chiropractic and acupuncture appointments. There is a $25.00 cancellation charge for missed or cancelled appointments with less than 24 hours notice. You will be billed directly for any cancellation charges.

**ACKNOWLEDGMENT AND UNDERSTANDING:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and payable.

In the event that my account is forwarded to a collection agency, a charge of 35% of the ENTIRE balance will be applied for proper processing and settlement of the account. The collection agency also charges daily interest. There is a $35 non-sufficient funds fee for returned checks in addition to what the bank charges for this office for
a non-sufficient funds returned check. We reserve the right to charge a 5% service charge per month on any unpaid balances beyond 60 days. Please notify us in advance if there are any circumstances that prevent you from meeting these financial arrangements.

Notice of Privacy Practices for Protected Health Information

The health and billing records we maintain are the physical property of N2Health. The information in it, however, belongs to you. You have the right to:
• Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to N2Health. We are not required to grant the request but we will comply with any request granted;
• Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request to N2Health;
• Request that you be allowed to inspect and copy your health record and billing record. You may exercise this right by delivering a request in writing to N2Health;
• Appeal a denial of access to your protected health information except in certain circumstances;
• Request that your healthcare record be amended to correct incomplete or incorrect information by delivering a written request to N2Health. We are not required to make such amendments but we will respond to your request within 30 days.
• File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
• Obtain an accounting of disclosures of your health information required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information made to family members or friends in the course of providing care.
• Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office.

Our Responsibilities

N2Health - Chiropractic & Acupuncture is required to:
• Maintain the privacy of your health information as required by law,
• Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
• Abide by the terms of this “Notice”;
• Accommodate your reasonable requests regarding methods of communicated health information with you.

We reserve the right to amend, change or eliminate provisions in our privacy practices and access practices and enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our “Notice”. You are entitled to receive a copy of the “Notice” by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

I agree to the above financial and privacy forms.
MEDICAL RECORDS REQUEST FORM

Patient: ________________________________

Date of Birth: ________________ Social Security Number: ________________

I, the undersigned, hereby authorize and request

(Doctor and/or Hospital )

(Address)

(Phone) (Fax)

to provide one of more of the following:
1) Medical Records (history, exam, treatment records)
2) X-rays (films and reports)
3) MRI / CT Scan (films and reports)
4) EMG / NCV / SSER (reports)
5) Other (specify) ________________________________

in your possession, concerning my illness and/or treatment. During the period of
________________________ to PRESENT, for the purpose of ________________________________.

Release or transfer of the specified information to any person or entity not specified herein
is prohibited. An additional written consent must be obtained for a proposed new use of
the information or its transfer to another person or entity.

The authorization shall be valid until _________________________________.

(date)

I understand that I have a right to receive a copy of this authorization upon my request.

(Patient or Parent/Guardian Signature) (Printed Name of Patient) (Date)

(Patient's Address) (City, State, Zip)

(Witnessed By) (Date)

Date Request Faxed/Mailed __________