Healing Arts Center of Lenexa
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Auto Accident

Incident Information

Date of incident: _____ / _____ / _____
Time of incident: _____ AM PM
What state did the incident occur in? _____
Please explain in detail what occurred:
_____
_____
_____
_____
_____
_____
_____
_____

Were you wearing your seat belt? Yes No

How fast were you traveling?_____ mph

How fast do you estimate the other car was traveling?_____ mph

Were your breaks applied? Yes No

Which direction were you heading?_____

Where were you struck?
Behind Front Left Side Right Side

Where in the car were you?
Driver Passenger-Front Passenger-Back

Number of people in the car?_____
Were the police notified? Yes No

Did you strike your head on any object?
Yes No

Were you knocked unconscious? Yes No
If yes, for how long?_____

Patient Information

Today's date: _____ / _____ / _____
Name: _____
Date of birth: _____ / _____ / _____
Phone Number: _____
Address:_____
_____

Your Insurance Info

Insurance Co: _____
Address: _____
City: _____ State: ____ Zip: _____
Policy No.: _____
Claim No.: _____
Adjustor Name: _____
Adjustor Phone No: _____

Have you retained an attorney?
Yes No Not Yet
If yes, please answer the following:
Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone Number: _____

Other Party's Insurance Info

Name: _____
Insurance Co: _____
Address: _____
City: _____ State: ____ Zip: _____
Policy No.: _____
Claim No.: _____
Adjustor Name: _____
Adjustor Phone **#:** _____

Patient Name:_____ Date of Birth:_____

Medical Information

When did you feel pain after the accident? Immediately Later that day Next day

Where did you feel pain after the accident?

_____

Where were you taken after the accident?

_____

Was a doctor consulted after the accident occurred? YES NO

If yes, please provide the following:

Name: _____

Phone#:_____

Doctor's Diagnosis:

_____

Was any treatment given? If so what type?_____

How often and how long did you see this doctor?

_____

Have you ever had any complaints in the involved area before? YES NO If yes, what were the complaints?

_____

_____

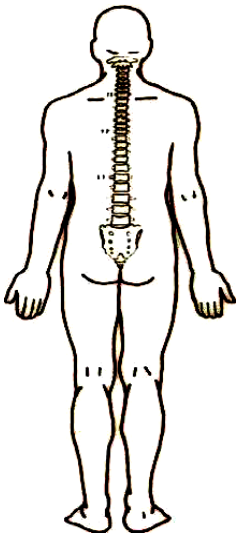
Before the injury, were you capable of working on an equal basis with others your age? YES NO

Are your work activities restricted now? YES NO

Since the injury, are your symptoms: Improving Getting Worse Same

Select region of pain and circle the number indicating the pain's severity

Burning • Stabbing • Sharp • Constant



EXAMPLE: NECK _____Sharp_____

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

NECK _____

1 2 3 4 5 6 7 8 9 10

MID BACK _____

1 2 3 4 5 6 7 8 9 10

LOW BACK _____

1 2 3 4 5 6 7 8 9 10

HIPS _____

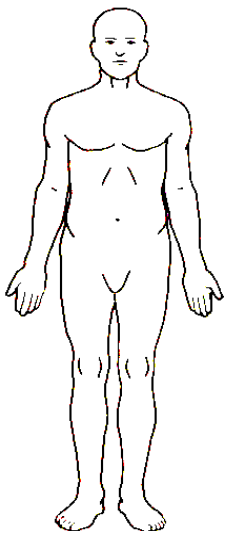
1 2 3 4 5 6 7 8 9 10

ARMS _____

1 2 3 4 5 6 7 8 9 10

LEGS _____

1 2 3 4 5 6 7 8 9 10



Please draw on the figures where you have any of the following:

A= Ache SF= Stiffness SH= Sharp S= Soreness N= Numbness P= Pain C= Constant XX= Other

Patient Name:_____ **Date of Birth:**_____

Please identify how any of your current conditions is affecting your ability to carry out activities that may be routinely part of your life.

Walking	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Reading	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Gardening	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dancing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Shoveling	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Watching T.V.	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting to Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sexual Activity	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Bending	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Climbing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Concentrating	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Recreation	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform

CONSENT FOR TREATMENT

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic x-rays on the named patient, for whom I am legally responsible, by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the Healing Arts Center of Lenexa. I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with the doctor of chiropractic named below and/or with other clinic personnel. I understand that results are not guaranteed. I understand that in the practice of chiropractic, as in the presence of medicine, there are some risks. I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely upon the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time is in the patient's best interest, based upon the facts then known to him or her. I have also had the opportunity to ask questions about is content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Eugene Lockrow, DC **Brenda Casey, DC** **Mike Hamilton, DC** **Emilio John, DC**
Nicholas Lockrow, DC **Colton Bartels, DC** **Blain Kingsbury, DC, RTP, BCIM**
Katherine Kubovy, DC, DABCI