Healing Arts Center of Lenexa
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Personal Injury

Patient Information

Today's date: _____ / _____ / _____
Name: _____
Date of birth: _____ / _____ / _____

Incident Information

Date of incident: _____ / _____ / _____
Time of incident: _____ AM PM
What state did the incident occur in? _____
Please explain in detail what occurred:
_____
_____
_____
_____
_____
_____
_____
_____
Number of people involved? _____
Were the police notified? Yes No
Did your head strike any object? Yes No
Were you knocked unconscious? Yes No
If yes, for how long? _____
Were there any witnesses? If yes, please list names: _____
_____

Other Party's Insurance Info

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

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: _____

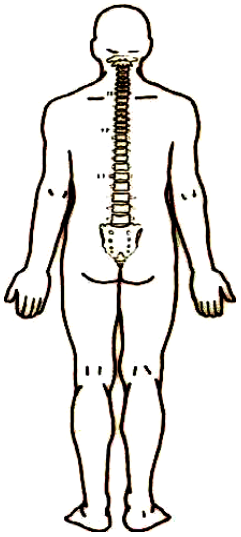
Medical Information

When did you feel pain after the incident?
Immediately Later that day Next day
Where did you feel pain after the incident?
_____
Where did you go after the incident?
_____
Was any doctor consulted after the incident occurred? Yes No
If yes, please provide the following:
Name: _____
Phone: _____
Doctor's Diagnosis:
_____
Was any treatment given? 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?
_____
Do you have any congenital (from birth) factors which relate to this? Yes No
List:_____
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

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

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 _____

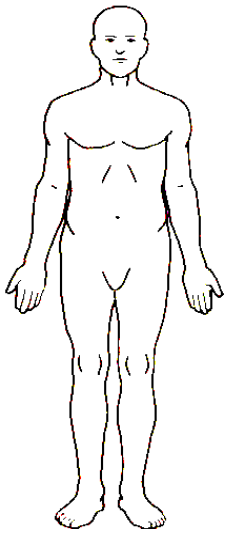
1 2 3 4 5 6 7 8 9 10

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

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

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

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: _____