Patient #_____
(for office use only)

LaBounty Family Chiropractic

1310 SW State St Ste B, Ankeny, IA, 50023 Phone: 515-965-8280

PERSONAL INJURY

Personal and Confidential Information **Accident Date:**

First Name:	Middle Initial:	Nickname:
Last Name:		
Guardian's Name (*if aged 6-17*)	First Name:	Last Name:

DOB:	Age:	SSN:	Gender: **M** or **F**
Cell #: ( )	Cell phone provider: (*for text reminders*)		Home #: ( )
Marital Status: **S M W D**	Spouses Name (if applicable)		

Address:	City/State:	Zip:
Email:	Do you want email reminders in addition to text reminders? **Y** or **N**	
Name of person(s) we may discuss care /account with?		
Preferred method of communication: 0 Email 0 Phone 0 Text	How did you find out about our office?	If referred, by whom?

Personal Medical History: *circle Ⓝ for **Now** and/or Ⓟ for **Past***

New or **P**ast Allergies	**N** or **P** Constipation	**N** or **P** Irreg Heart Beat	**N** or **P** Prostate Trouble
New or **P**ast Alcoholism	**N** or **P** Cramps	**N** or **P** Headache	**N** or **P** Sciatica
New or **P**ast Anemia	**N** or **P** Depression	**N** or **P** Hot Flashes	**N** or **P** Short of Breath
New or **P**ast Arteriosclerosis	**N** or **P** Diabetes (type 1 or 2)	**N** or **P** Kidney Infection	**N** or **P** Sinus Infection
New or **P**ast Arthritis	**N** or **P** Digestion Trouble	**N** or **P** Kidney Stones	**N** or **P** Spinal Curvatures
New or **P**ast Asthma	**N** or **P** Dizziness	**N** or **P** Loss of Balance	**N** or **P** Stroke
New or **P**ast Back Pain	**N** or **P** Eye Pain	**N** or **P** Loss of Memory	**N** or **P** Swelling of Ankles
New or **P**ast Breast Lump	**N** or **P** Fatigue	**N** or **P** Loss of Smell	**N** or **P** Swollen Joints
New or **P**ast Bronchitis	**N** or **P** Frequent Urination	**N** or **P** Loss of Taste	**N** or **P** Thyroid Condition
New or **P**ast Bruise Easily	**N** or **P** Irregular Menstrual	**N** or **P** Nosebleeds	**N** or **P** Tuberculosis
New or **P**ast Cancer	**N** or **P** Hemorrhoids	**N** or **P** Pacemaker	**N** or **P** Ulcers
New or **P**ast Chest Pain	**N** or **P** High BP	**N** or **P** Poor Posture	**N** or **P** Varicose Veins
New or **P**ast Cold Extremities	**N** or **P** Insomnia		

Surgeries:

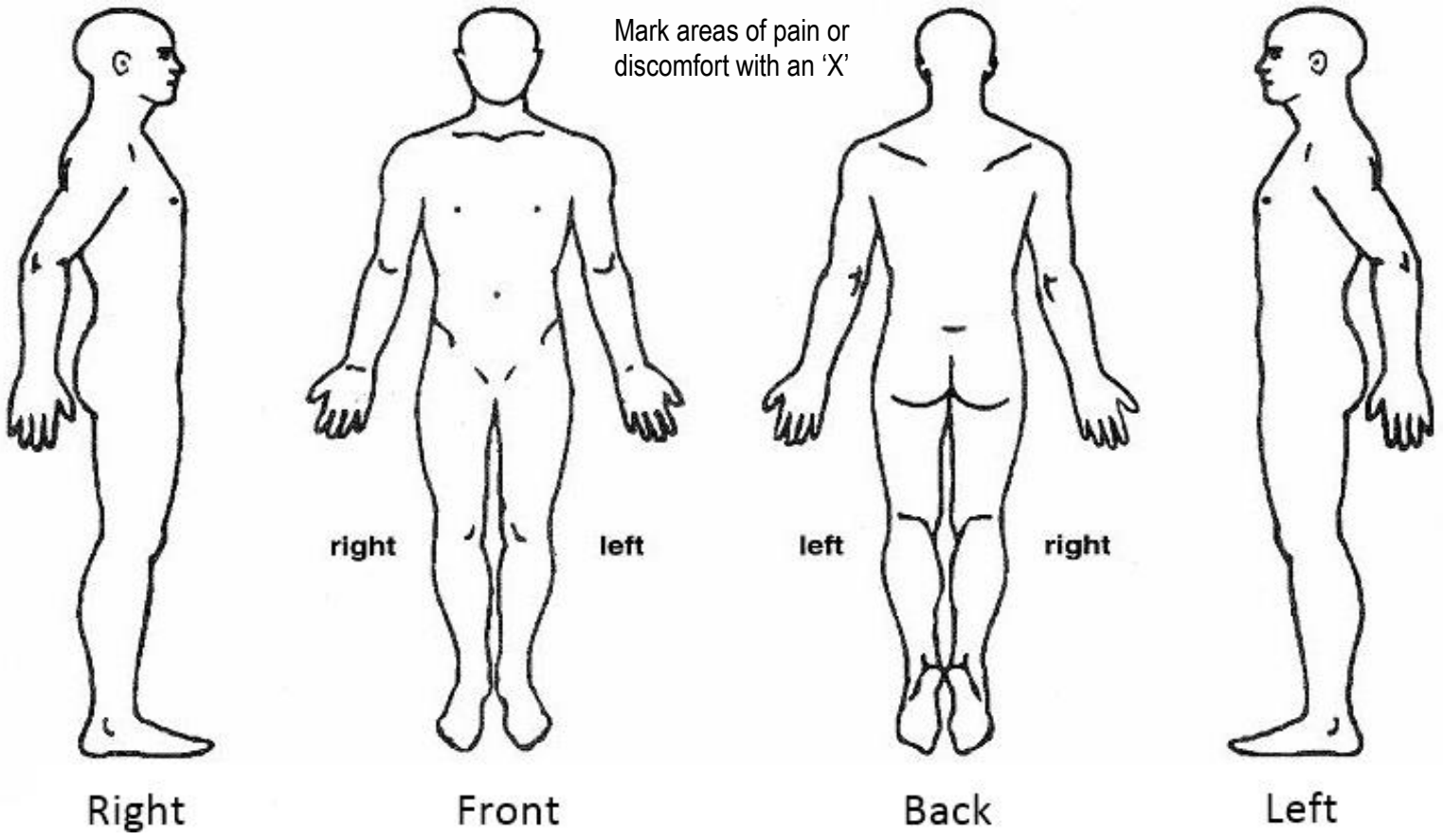
Illnesses:

Accidents, Falls, Traumas

Do you smoke? Y or N **Do you drink alcohol? Y or N** **Do you drink tea, coffee, or soda? Y or N**

Medications/Supplements:

Allergic Reactions to Medicine:



Primary Complaint:		
When did you first notice it?		
What were you doing?		
Where is the symptom?		
Where does it travel?		
Sharp Dull Aching Burning Numb Throbbing Radiating (circle)	**☺ 1-2-3-4-5-6-7-8-9-10**	**When 25% 50% 75% 100%**
What makes it better?	**What makes it worse?**	
Difficult movements?	**Difficult activities?**	
What have you tried?	**Have you had this symptom before?**	

LaBounty Family Chiropractic
Functional Rating Index (FRI)

In order to properly assess your condition, we must understand how your **neck and/or back problems** have affected your ability to manage every day activities. For each item below, **please circle the answer which most closely describes your condition today**.

Office Use Only:
Score _____
% _____

Name: _____ **Date:** _____

1. Pain Intensity	No pain (0)	Mild pain (1)	Moderate pain (2)	Severe pain (3)	Worst possible pain (4)
2. Sleeping	Perfect sleep (0)	Mildly disturbed sleep (1)	Moderately disturbed sleep (2)	Greatly disturbed sleep (3)	Totally disturbed sleep (4)
3. Personal Care (washing, dressing, etc.)	No pain, no restrictions (0)	Mild pain, no restrictions (1)	Moderate pain, need to go slowly (2)	Moderate pain, need some assistance (3)	Severe pain, need 100% assistance (4)
4. Travel (driving, riding in vehicle, etc.)	No pain on long trips (0)	Mild pain on long trips (1)	Moderate pain on long trips (2)	Moderate pain on short trips (3)	Severe pain on short trips (4)
5. Work	Can do normal work plus unlimited extra work (0)	Can do normal work, no extra work (1)	Can do 50% of normal work (2)	Can do 25% of normal work (3)	Cannot work (4)
6. Recreation	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do few activities (3)	Cannot do any activities (4)
7. Frequency of pain	No pain (0)	Occasional pain, 25% of day (1)	Intermittent pain, 50% of day (2)	Frequent pain, 75% of day (3)	Constant pain, 100% of day (4)
8. Lifting	No pain with heavy weight (0)	Increased pain with heavy weight (1)	Increased pain with moderate weight (2)	Increased pain with light weight (3)	Increased pain with any weight (4)
9. Walking	No pain, any distance (0)	Increased pain after 1 mile (1)	Increased pain after ½ mile (2)	Increased pain after ¼ mile (3)	Increased pain, any distance (4)
10. Standing	No pain after several hours (0)	Increased pain after several hours (1)	Increased pain after 1 hour (2)	Increased pain after ½ hour (3)	Increased pain with any standing (4)

Staff Only:
Information Taken By_____ Date _____
Reviewed By_____ Date _____

LaBounty Family Chiropractic
ACCIDENT INJURY

Date of Accident: _____ Time: _____(AM) (PM)
Location of the Accident: _____

Did you strike the other car? ( ) Yes ( ) No
Did the other car strike your car? ( ) Yes ( ) No
Were you? ( ) Driver ( ) Passenger
Were you struck from? ( ) Behind ( ) Front ( ) Rt. ( ) Lt.
Were Traffic Citations issued to your car? ( ) Yes ( ) No
Were Traffic Citations issued to the other car? ( ) Yes ( ) No
Were you wearing your seat belt? ( ) Yes ( ) No
What was your position in the vehicle at the time of impact?

_____

What injuries did you sustain during the accident?

_____

Head: _____ Arms: _____ Feet: _____ Legs: _____
List any <u>new</u> symptoms: _____
List <u>old</u> symptoms that are worse:_____
List <u>old</u> symptoms that were not affected by the accident:

_____

Did you require post-accident hospitalization? ( ) Yes ( ) No
If yes, what care did you receive and where?

_____

Have you lost any days from work? ( ) Yes ( ) No
If yes, dates of loss: _____
Employed by: _____

Do you have an attorney? ( ) Yes ( ) No
If yes, attorney's name: _____
Address: _____
Phone: _____

Name: _____Signature:_____Date:_____

1310 SW State Street Suite B, Ankeny, Iowa 50023

LaBounty Family Chiropractic
Personal Injury / Car Accident Payment Options

There are two options to cover chiropractic care in our office:

1) Use the Medical Pay Option from YOUR car insurance.
2) Pay cash or Health insurance if they allow.

***Regardless* of which you choose we will need the following information:**

YOUR CAR Insurance Name: _____

Address of *your* Car Insurance: _____

Phone # of this Insurance: _____

Med Pay Claim #: _____

Med Pay Rep Name: _____

Rep's Phone #: _____

Rep's Fax #: _____

We need below information *if* you are *not at fault*. In addition to billing your company monthly, we will bill their company to keep them informed of your care.

Other Driver's Car Insurance: _____

Address: _____

Claim #: _____

Rep's Name & phone #: _____

Fax #: _____

*We will *also* bill you monthly to keep you informed. You are ultimately responsible for your bill. Med pay accounts have maximum limits you will want to be watching so you know if you will need to pay in cash.

*If you are not at fault, you will have an opportunity to seek pain and suffering reimbursement from their insurance company above what would be paid to cover medical expenses.

*It is our job to return your spine as close as we can to pre-accident status.

1310 SW State St
Suite B
Ankeny, IA 50023

Phone: (515) 965-8280
Fax: (515) 963-4401
patients@labountychiropractic.com

Authorization for the Release of Medical Records

Patient Name:_____ Date of Birth:_____

I authorize LaBounty Family Chiropractic & Dr. _____ to release my personal health care information to:

[ ] Self [ ] Dr/Clinic: _____ [ ] Other: _____

Please select 1 of the following:

[ ] Email to: (digital files-jpeg & pdf) ____ X-rays ____ Adjustments and Exam Notes

Email address: _____

[ ] Pick-up in clinic: ____ X-rays (on CD) ____ Adjustments and Exam Notes

for contact: _____

[ ] Fax Records: ____ Patient File SOAP notes

Attn name & fax #:_____

[ ] Mail to:

Address:_____

City/State:_____ Zip:_____

This authorization will be effective for 1 year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Signature: _____Date:_____
(Signature of Patient or Legal Guardian if under age 18)

Office Use Only:
Initial or N/A: _____ request given to Dr./Intern _____ request completed
_____ patient notified/note on next appt _____ CD/Papers in TBPU folder

LaBounty Family Chiropractic Terms of Acceptance

Chiropractic has only one goal - to serve the health needs of you, the patient. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine, as well as extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, then do an analysis, and then develop a treatment for the extremity and synchronize this plan with the plan for the spinal treatment.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral.

We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient. We are here for your health!

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-ray Release

This is to certify that Dr. LaBounty, Dr. Deal, & Dr. Larson have my permission to perform an X-ray evaluation. **To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.** Date of last menstrual period:_____

Consent to Care for Minor

I authorize Dr. LaBounty, Dr. Deal, & Dr. Larson to administer care as they so deem necessary to my minor dependent.

Payment / Insurance

I understand that Dr. LaBounty, Dr. Deal, and Dr. Larson will provide a receipt to assist me in making collection from any insurance company. I clearly understand 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read and understand the above and I agree to these policies and procedures. All questions about this page have been answered to my satisfaction and I therefor accept care at LaBounty Family Chiropractic on this basis. Check all that apply:

☐ Terms of Acceptance ☐ Patient Health Information ☐ Consent Form ☐ X-ray Release ☐ Minor Consent

Signature: **Date:**