CopperWell Chiropractic & Massage

Auto Injury Form

5069 W 13400 S Ste 100 Herriman UT 84096

First Name: _____ Last Name:_____

Home Address: _____City: _____ State: _____ Zip: _____

Email: _____Cell: (____)_____ Date of Birth: ____/____/____

Auto Accident Insurance Company:_____ Date of Accident:____/____/____

Claim #:_____ Adjuster Name:_____ Phone #:_____

Lawyer Name:_____Law Firm:_____Phone #:_____

Accident Information:

(Circle all that apply)

1. Rear Ended Head on Collision Hit on Passenger Side Hit on Driver Side Roll Over

2. Driver Front Passenger Middle Back Back Right Passenger Back Left Passenger

3. Were there other occupants in your vehicle? Y N

4. Your type of vehicle:_____ Other Vehicles involved:_____

5. Were the vehicles drivable? Yours: Y N Others involved Y N

6. Seat Belt? Y N Loss of consciousness? Y N Airbags Deployed? Y N

7. List all places you have been seen for this auto accident (ER, Doctor office, Instacare):

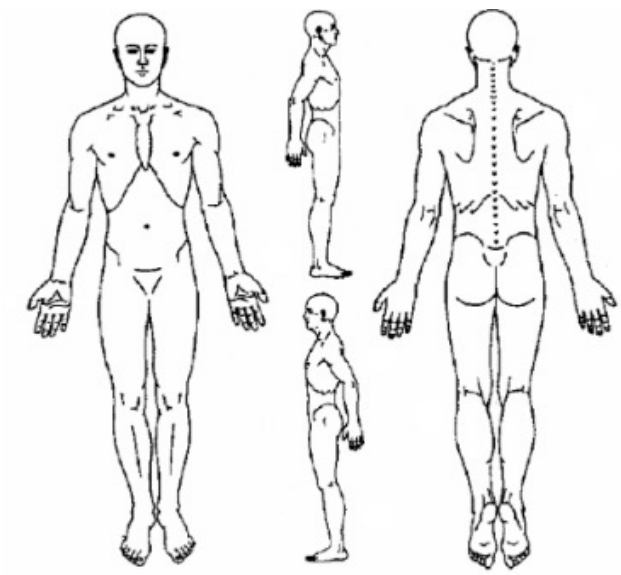
_____

_____

8. Was imaging performed? NO XRAY MRI CT Other:_____

ABOUT YOUR PAIN

Show us where you have pain



Headache?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Neck Pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Mid Back Pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Low Back Pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Rt Shoulder pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
L Shoulder Pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Rt Hip Pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
L Hip Pain?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Rt Arm/Wrist?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
L Arm/Wrist?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
Rt Leg/Ankle?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
L Leg/Ankle?	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
_____	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10
_____	Y	N	Pain Scale:	1	2	3	4	5	6	7	8	9	10

Describe your pain/injuries in your own words?

What best describes your pain? Circle all that apply

Aching Shooting Sharp Burning Numb Tender Stabbing Throbbing Miserable Unbearable Exhausting

What time of day is your pain the Worst? Circle all that apply

Morning upon arising Later in the morning Afternoon Evening Night Bedtime Pain Always the Same Varies

Does anything make your pain BETTER? Circle all that apply

Rest Ice Heat Stretching Pain medication Massage Exercise Walking Laying Down Standing
Sitting Sleeping Biofreeze Physical Therapy Decompression Chiropractic adjustments

Does anything make your pain WORSE? Circle all that apply

Rest Ice Heat Stretching Pain medication Lifting Massage Exercise Walking Standing
Sitting Work Laying down Sleeping Physical Therapy Decompression Chiropractic adjustments

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

Have you been treated for any conditions in the last year? Yes ☐ No ☐ If yes, please describe _____

_____

Date of last physical _____ Have you had x-rays taken? Yes ☐ No ☐ If yes, where & when? _____

What medications or drugs are you taking and for what conditions? (Please list dosage and frequency)

_____

_____

What vitamins, minerals, or herbs do you currently take and for what conditions? (Please list dosage and frequency)

_____

_____

Please list all allergies _____

WOMEN: Are you/could you be pregnant? Yes ☐ No ☐ If yes, due date? _____ Date of last period? _____

Please check any conditions you currently have or have had in the past:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Appendicitis
☐ Atherlerosclerosis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Back pain
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Cataracts
☐ Chest Pains/Tightness
☐ Chicken Pox
☐ Circulation Problems
☐ Cold Extremities
☐ Constipation
☐ Coughing Blood
☐ Cramps
☐ Depression
☐ Diabetes
☐ Difficulty Urinating
☐ Digestion Problems

☐ Dizziness
☐ Emphysema
☐ Epilepsy/Seizures
☐ Fainting
☐ Fatigue
☐ Fractures/Broken Bones
☐ Frequent Colds
☐ Frequent Urination
☐ Gall Bladder Problems
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Headaches
☐ Heart Disease
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hot Flashes
☐ Hypoglycemia
☐ Indigestion Problems
☐ Irregular Heart Beat
☐ Irregular Cycle
☐ Kidney Disease
☐ Kidney Infection
☐ Kidney Stones

☐ Liver Disease
☐ Loss of Memory
☐ Loss of Balance
☐ Loss of Smell
☐ Loss of Taste
☐ Low Blood Pressure
☐ Measles
☐ Migraines
☐ Miscarriage
☐ Mono
☐ Multiple Sclerosis
☐ Muscle Spasms
☐ Mumps
☐ Neck Pain/Stiffness
☐ Nervousness
☐ Nosebleeds
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Poor Posture
☐ Prostate Problems
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis

☐ Rheumatic Fever
☐ Ringing of the Ears
☐ Scarlet Fever
☐ Sciatica
☐ Shortness of Breath
☐ Sinus Infection
☐ Sleeping Problems
☐ Spinal Curvatures
☐ Stroke
☐ Swelling of Ankles
☐ Swollen Joints
☐ Tension
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Typhoid Fever
☐ Ulcers
☐ Unusual Bowel Patterns
☐ Vaginal Infection
☐ Varicose Veins
☐ Venereal Disease
☐ Weakness in Extremities
☐ Weight Gain/Loss
☐ Whooping Cough
☐ Other Conditions
Diagnosed by a Doctor:
_____
_____
_____

Have you ever:

Broken Bones? Yes ☐ No ☐ If yes, briefly explain: _____
Been Hospitalized? Yes ☐ No ☐ If yes, briefly explain: _____
Been in an Auto Accident? Yes ☐ No ☐ If yes, briefly explain: _____
Had Sprains/Strains? Yes ☐ No ☐ If yes, briefly explain: _____
Been Struck Unconscious? Yes ☐ No ☐ If yes, briefly explain: _____
Had Surgery? Yes ☐ No ☐ If yes, briefly explain: _____

Auto Case/Personal Injury Policy

Auto cases and personal injury cases are a stressful time for most patients. Our office and providers are here to help you. In the state of Utah personal injury policies connected to your auto insurance has a maximum in general of $3000, after which a lawyer might need to be contacted depending on the personal case. If care is extended past the PIP and the office feels it is medically related to your accident the office will require a small payment at each visit as some cases can take years for settlement. This allows us to keep working on you and keeping your costs down as well as accounting for supples needed at the time. An example of this policy would be if there is no coverage through insurance a person might have a $30 fee for massage therapy.

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments, and other chiropractic or massage procedures, including various modes of physiotherapy and decompression and massage therapy/muscle work by CopperWell Chiropractic physicians and/or its employees/contractors. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand the results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its 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 my present condition and for any future condition(s) for which I seek treatment from CopperWell Chiropractic.

I understand that the massage given to me is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, and/or offers a positive experience of touch. I understand that this is not to diagnose illness or disease and I will not receive a prescription for medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. I understand that massage is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes especially the use of corticosteroids.

Cancellation and Missed Appointment Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice."No-shows," arriving late and late cancellations inconvenience those individuals who need access to medical care in a timely manner. To cancel appointments, please call 801.253.8141 or your provider directly as you must cancel with a person and not over voicemail.

First missed appointment: $35 fee will be billed to your account
Second missed appointment: $50 fee will be billed to your account
Third missed appointment: price of all services booked will be billed to your account and you may be discharged

The Cancellation and No Show fees are the sole responsibility of the patient and <u>must be paid in full before the patient's next appointment</u>.

By signing below you acknowledge all policies stated as well as attest to the information provided being accurate to the best of your knowledge. You also agree to notify the office with any changes to your record or medical history as soon as possible

Signature: _____ **Printed Name:** _____ **Date:** ____/____/____