

PLEASE PRINT ALL INFORMATION CLEARLY Today's Date _____

Name: _____

Date of Birth: _____ Age: _____ Male Female

Height: _____ Feet _____ Inches Weight: _____ Pounds

Address: _____ Home Tel# _____

_____ Cell # _____

City State Zip code

E-Mail Address: _____

Driver's License #: _____ State: _____

Emergency Contact: _____ Phone # _____

INSURANCE INFORMATION

PLEASE PROVIDE TO THE FRONT DESK FOR COPYING

1. YOUR PHOTO ID/DRIVER'S LICENSE: Provided: Yes No

2. YOUR AUTO INSURANCE CARD: Yes No

YOUR WORKER'S COMPENSATION INFORMATION:

3. YOUR GENERAL HEALTH INSURANCE CARD: Yes No

Auto/Worker's Compensation Insurance Company: _____

Date of Accident: _____ State Accident Occurred: _____

Has Insurance Carrier been notified: Yes No

If yes, were you assigned a Claim Number: Yes No

If yes, Claim Number: _____

IF NAME ON THE POLICY IS DIFFERENT THEN YOURS (Policy Holder Is: Parent, Spouse...)

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Age: _____ Male Female

Health Insurance Company: _____

Policy Number: _____ Group# _____

IF PATIENT IS DIFFERENT FROM POLICY HOLDER (Policy Holder Is: Parent, Spouse...)

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Age: _____ Male Female

IS THERE AN ATTORNEY: Yes No

IF YES, NAME OF ATTORNEY: _____

CONTACT NUMBER: _____

IN ORDER FOR THIS OFFICE AND ITS PHYSICIAN TO BETTER HELP YOU

**PLEASE COMPLETE THE FOLLOWING QUESTIONS
USE BACK OF PAGES IF FURTHER INFORMATION IS NEEDED**

- INJURIES DUE TO:** **MOTOR VEHICLE ACCIDENT**
1. **I WAS DRIVER**
- a. **SEATBELT:** Yes No
2. **I WAS PASSENGER**
- a. **SEATBELT:** Yes No
- b. **SITTING IN FRONT**
- c. **SITTING IN REAR**
- SLIP AND FALL**
- WORK RELATED INJURY**

DATE OF ACCIDENT/INJURY: _____

HOW DID ACCIDENT HAPPEN: _____

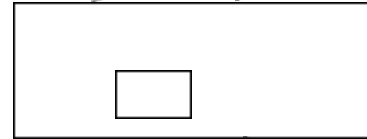
IF MOTOR VEHICLE ACCIDENT

- Stopped:** Yes No
- Traveling Forward:** Yes No **If yes** _____ **MPH**
- Turning:** Yes No **If yes:** Right Left
- Backing up:** Yes No

Mark area vehicle was hit:

Front

Rear



POLICE RESPONDED: Yes No

FIRE RESCUE/PARAMEDICS RESPONDED: Yes No

TRANSPORTED TO HOSPITAL BY AMBULANCE: Yes

No

IF YES, NAME OF HOSPITAL: _____

TREATMENT PROVIDED: _____

TOOK SELF TO HOSPITAL/WALK IN CLINIC: Yes No **Date:**

=====

IF YES, NAME OF HOSPITAL/CLINIC: _____

TREATMENT PROVIDED: _____

FOLLOWED UP WITH MY DOCTOR: Yes No **Date:**

IF YES, NAME OF YOUR DOCTOR: _____

TREATMENT PROVIDED: _____

FOLLOWED UP WITH OTHER DOCTOR: Yes No **Date:**

IF YES, NAME OF OTHER DOCTOR: _____

TREATMENT PROVIDED: _____

Initial: _____

**PLEASE LIST ALL OF YOUR CURRENT COMPLAINTS IN ORDER OF PRIORITY
USE BACK OF PAGE IF FURTHER INFORMATION IS NEEDED**

***Pain Scale: Where “ 0 ” is NO PAIN and “ 10 ” is the WORSE PAIN EVER**

	Area of Complaint	Constant or Intermittent	Type of pain Sharp/dull/burn/numb	Pain scale *0 to 10	Radiating into/down (example: eye, arm)
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

I HAVE DIFFICULTY PERFORMING ADL/ACTIVITIES OF DAILY LIVING

- | | | | |
|--|-----------------------------|--|--|
| Carrying Groceries..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Sit to Stand..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Climbing Stairs..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Pet Care..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Driving..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Working on Computer..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Household Chores..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Sweeping/Vacuuming..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Standing Washing Dishes..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Doing Laundry..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Taking Out the Garbage..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Lifting Child to Care For or Play With... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Reading/Concentration..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Bathing Self..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Getting Dressing..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Shaving..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Personal relations with significant other: | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Sleeping..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Prolonged Sitting..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Prolonged Standing..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| General Yard Work..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |
| Extended Walking..... | <input type="checkbox"/> No | <input type="checkbox"/> Some Difficulty | <input type="checkbox"/> Unable to perform |

Initial: _____

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do daily tasks at this time. Please answer every question by marking an “X” along the line to show how your pain problems has affected you

1. Does your pain interfere with your normal work inside and outside the home?

Work normally 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Unable to work at all*

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Need help with all my personal care*

3. Does your pain interfere with your traveling?

Travel anywhere I like 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Only travel to see doctors*

4. Does your pain affect your ability to sit or stand?

No problems 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot sit or stand at all*

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot do at all*

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot do at all*

7. Does your pain affect your ability to walk or run?

No problems 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Cannot walk/run at all*

8. Has your income declined since your pain began?

No decline 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Lost all in come*

9. Do you have to take pain medication every day to control your pain?

No medication needed 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Take pain medication throughout the day*

10. Does your pain force you to see doctors more often than before your pain began?

Never seen doctors 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Seen doctors weekly*

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No Problems

Never see them

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No Interference

Total interference

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help

Need help all the time

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension

Severe depression/tension

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?

No problems

Severe problems

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

AMA Guides 6th Edition Pg. 43 and 44

Patient Acknowledgement

By my signature, I understand and acknowledge that Rhode 2 Wellness Family Chiropractic, its Physicians and agents will treat my condition as they deem necessary through the use of Chiropractic Therapy and adjunctive therapies. I also understand that all original documents and original x-rays created as a result of the performance of examinations will remain the property of Rhode 2 Wellness Family Chiropractic. Rhode 2 Wellness Family Chiropractic, it's Physicians and agents will not be held responsible for any undisclosed pre-existing conditions.

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

I understand I am responsible for any and all charges accrued unless previous agreement has been agreed upon between us

Print Name: _____

Signature: _____

Date: _____

Parent or guardian if patient is a minor Mother Father

Legal Guardian

Print Name: _____

Signature: _____

Date: _____

Rhode2WellnessFamilyChiropractic

Patient 's Name

Date

DOB

Automobile/PI Accident or Work Comp Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please explain in detail how your accident happened:

What were the time and date of present injury?

Where did you feel pain immediately after the accident?

List the extent of your injuries as you know them:

Check symptoms you have noticed since the accident:

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head seems too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Shortness of Breath | | |

Symptoms other than above:

Rhode 2 Wellness Family Chiropractic

Patient 's Name

Date

DOB

Did you lose consciousness at any time? Yes/No _____ If yes, for how long _____

Did any parts of your body get struck/hit anything? Yes/No _____ If yes, please explain below

Where were you taken after the accident?

Hospitalized? Yes/ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctors: _____

What treatment was given?

Was any other doctor consulted after your accident? Yes/ No _____

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis?

What treatment were given?

How long did you see the doctor?

Have you ever had any complaints in the involved area before? Yes/ No

If so, 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 as a result of this accident? Yes/ No

Patient 's Name

Date

DOB

Rhode 2 Wellness Family Chiropractic

Since this injury, are your symptoms (circle one): Improving? Getting worse? Same?

Driver of other vehicle (if any)

Name: _____ Insurance Company: _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name: _____ Insurance Company: _____ Policy No. _____

Name of your insurance adjustor:

Have you retained an attorney? Yes/ No

If so, his name and address:

You were heading North / East / South / West on _____ (street or highway)

Other vehicle was heading North / East / South / West on _____ (street or highway)

Were police notified? Yes/ No

You were struck from Behind/ Front/ Left Side/ Right Side

You were Driver / Passenger / Front Seat / Back Seat / Using seat belts

Patient Signature

DATE

Doctor Signature

DATE

Rhode 2 Wellness Family Chiropractic

Date _____

TO _____

Patient: _____

Claim#: _____

Medical Claim# _____

DOA: _____

Dear Adjuster,

Pursuant to Florida statutes, this letter is being sent to notify you that this clinic is currently evaluating and providing treatment to the above-named patient.

Evaluations and treatments are for injuries sustained as a result of an automobile accident on the above date.

Treatment records and billing claims will be forwarded within the mandated time frame.

Rhode 2 Wellness Family Chiropractic

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. Thank You.

TO: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

YOUR NAME	PHONE NO. <small>(Include Area Code)</small>	HOME	BUSINESS
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YOUR ADDRESS (No, Street, City or Town, State & Zip Code) <small>Permanent Address if Different</small>	How Long Have You Lived In Florida?	Date of Birth	Social Security #
--	-------------------------------------	---------------	-------------------

Date and Time of Accident	A.M. P.M.	Place of Accident (Street, City or Town & State)
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Brief Description of Accident and Vehicles Involved: (If Additional Space is Needed, Use Reverse Side)

Describe Motor Vehicle You Own:

Describe Motor Vehicle Owned By Any Member of Your Family:

As a Result of This Accident Were You Injured? YES NO If Your Answer is Yes, Complete The Rest of This Form. If No, Sign Here and Return This Form To Us.

Signature _____ DATE _____

Describe Your Injury: (If Additional Space is Needed, Use Reverse Side)

Were You Treated By A Doctor YES <input type="checkbox"/> NO <input type="checkbox"/>	Doctor's Name and Address
--	---------------------------

If You Were Treated In A Hospital Were You AN IN-PATIENT? <input type="checkbox"/> OUT-PATIENT? <input type="checkbox"/>	Hospital's Name and Address
--	-----------------------------

Amount of Medical Bills To Date \$	Will You Have More Medical Expense? YES <input type="checkbox"/> NO <input type="checkbox"/>	At The Time of Your Accident Were You In The Course of Your Employment? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------------------	--	--

Did You Lose Wages or Salary As A Result Of Your Injury? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, Amount Lost To Date \$	What Is Your Average Weekly Wage or Salary? \$
---	--------------------------------	--

If You Lost Wages:	Date Disability From Work Began: / /	Date You Returned To Work: / /
--------------------	--------------------------------------	--------------------------------

Have you received or are you eligible for payments under any Workmen's Compensation or unemployment law? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, \$ Per Week Per Month
---	----------------------------------

List Names and Addresses of Your Present Employer(s) and Give Your Occupation and Dates of Employment for Each.

Employer and Address	Your Occupation	From	To
Employer and Address	Your Occupation	From	To

As A Result of Your Injury, Have You Had Any Other Expenses YES NO If "YES", Explain On Reverse Side

SIGNATURE: _____ DATE: _____

- IMPORTANT:
1. To Be Eligible For Benefits, Complete and Sign This Application
 2. Sign Attached Authorization(s)
 3. Return Promptly With Any Medical Bills You Have Received To Date