Dr. Goff's
Chiropractic & Wellness

WELCOME

Accident Injury Registration Form

PATIENT INFORMATION

Last Name, First Name MI | Title | Preferred Name

Date of Birth | Age | Gender | Marital Status | Spouse/Parent Name

Street Address | City | State | Zip

Mailing Address (if different) | City | State | Zip

SSN | Home Number | Cell Number | Work Number

Email (for private use by this office only) | Employer | Occupation

Whom may we thank for referring us to you? | Other family members seen here

EMERGENCY CONTACT

Name of local friend or relative (not living with you) | Home Phone | Cell Phone

INSURANCE INFORMATION

Your company | Company of other party

Claim Number | Adjuster Name | Phone

ATTORNEY INFORMATION

Name of Attorney | Phone

SYMPTOMS

	List your problems or complaints according to severity of pain	Rate Your Pain 0-10 (10=worst)
1		1 2 3 4 5 6 7 8 9 10
2		1 2 3 4 5 6 7 8 9 10
3		1 2 3 4 5 6 7 8 9 10
4		1 2 3 4 5 6 7 8 9 10
5		1 2 3 4 5 6 7 8 9 10
6		1 2 3 4 5 6 7 8 9 10

How would you describe the pain? □ Sharp □ Dull □ Diffuse□ Achy □ Burning □ Shooting □ Stiff □ Numb □ Tingly □ Sharp w/motion □ Shooting w/motion □ Stabbing w/motion □ Electric like w/motion

Is the problem? □ Getting worse □ Staying the same □ Getting better

How often do you experience your symptoms? □ Constantly (76-100%) □ Frequently (51-76%) □ Occasionally (26-50%) □ Intermittently (1-25%)

How much has the problem interfered with your normal activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your work/required tasks? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ Do not work

Do you consider your problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem? _____

What makes your problem feel better? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

How would you rate your overall health? □ Excellent □ Very good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Chronic Sinusitis	☐	☐	Dizziness
☐	☐	Neck Pain	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Upper Back Pain	☐	☐	Chest Pain	☐	☐	Excessive Thirst
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Frequent Urination
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Tobacco Use
☐	☐	Shoulder Pain	☐	☐	Kidney Stone	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorder	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Change	☐	☐	Other:
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer			
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	**For Females Only**		
☐	☐	Cancer	☐	☐	General Fatigue	☐	☐	Birth Control Pills
☐	☐	Tumor	☐	☐	Muscular Incoordination	☐	☐	Hormonal Replacement
☐	☐	Asthma	☐	☐	Visual Disturbances	☐	☐	Pregnancy

List all the prescription medications you are currently taking: _____

_____

_____

List all the vitamins/supplements you are currently taking: _____

_____

List all the surgical procedures you have had: _____

What activities do you do at work?

Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
Computer Work:	☐ Most of the day	☐ Half the day	☐ A little of the day
On the Phone:	☐ Most of the day	☐ Half the day	☐ A little of the day

What activities do you do outside of work? _____

Have you had any significant past trauma? _____

Anything else we should know? _____

ACCIDENT INFORMATION

Date of Accident _____ **Location of Accident** _____

How did Accident Occur: _____

_____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

How many vehicles were involved in the accident: _____

Your vehicle, make and model: _____ **Other** vehicle, make and model: _____

Where were you struck: ☐ Behind ☐ Front ☐ Right ☐ Left ☐ Auto Parked

Did your car strike other(s) involved? _____ **Did other car(s) strike yours**? _____

Did you know accident was coming? _____

Did your vehicle hit anything else? **If yes, please describe**: _____

During and after the accident what happened to your vehicle? (*check all that apply*)

☐ Kept going straight ☐ Kept going straight hitting a car in front ☐ Was hit by another vehicle

☐ Spun around ☐ Spun around and hit stationary object ☐ Hit a stationary object

Did you lose consciousness during accident? _____

How was your head positioned during accident? _____

Was any of the following hit by anything during the accident? If yes please describe: (*check all that apply)*

☐ Head _____
☐ Face _____
☐ Shoulders _____
☐ Neck _____
☐ Chest _____
☐ Hips _____
☐ Knees _____
☐ Feet _____

Were you wearing a seatbelt? _____ **Did airbag deploy?** _____ **Was headrest up?** _____

What was the damage to your vehicle? (*check all that apply)*

☐ windshield	☐ side window	☐ trunk	☐ back right door
☐ steering wheel	☐ rear window	☐ front driver door	☐ mirror
☐ dashboard	☐ rear bumper	☐ front passenger door	☐ knee bolster
☐ seat frame	☐ front bumper	☐ back left door	☐ vehicle totalled

MEDICAL TREATMENT

Was an ambulance at the scene? _____ **Were you treated at the scene?** _____

If treated at scene, what treatment was received? _____

Where you transported to hospital by EMS? _____ **Name of Hospital** _____

Treatment received at hospital including any x-rays taken, MRI done or CAT scans. _____

If you did not receive treatment at the time of the accident, when did you seek treatment? _____

Where did you seek treatment? ☐ Hospital ☐ Urgent Care ☐ Doctor Office ☐ Other: _____

Name of facility: _____

Treatment received after the accident including any x-rays taken, MRI or CAT scans. _____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I herby direct any and all insurance carriers, attorneys, governmental departments, companies, individuals, and/or other legal entities ("payers") which may elect or be obligated to pay benefits to me to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition") to pay directly to, and exclusively in the name of *Dr. Goff's Chiropractic & Wellness* (or "Office") such sums or may be owing to *Dr. Goff's Chiropractic & Wellness* for charges incurred by me, including but not limit to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me, at the Office ("charges"). I further grant a contractual lien to *Dr. Goff's Chiropractic & Wellness* with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by *Dr. Goff's Chiropractic & Wellness* to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event that a payer refuses to pay *Dr. Goff's Chiropractic & Wellness*, I hereby assign, in so far as permitted by law, all of my rights, remedies, and benefits to *Dr. Goff's Chiropractic & Wellness* to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such cause of action either in my name or in the Offices name and to settle or otherwise resolve such causes of action as the Office sees fit.

In event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this Office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office. I further direct each attorney to provide immediate notice of the Office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the Office upon request. I understand that full payment may be due 60 days after release of care from *Dr. Goff's Chiropractic & Wellness* regardless of whether a settlement has been issued in my case.

I hereby direct all payers to release to *Dr. Goff's Chiropractic & Wellness* and information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far , and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize *Dr. Goff's Chiropractic & Wellness* to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize *Dr. Goff's Chiropractic & Wellness* to apply any credit balances on charges incurred by me to any other outstanding charges still owed by my spouse, my dependents, regardless of whether these other charges are related to my condition or me.

I understand that I remain personally responsible for the total amount due *Dr. Goff's Chiropractic & Wellness* for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payment from me immediately upon rendering services and its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse *Dr. Goff's Chiropractic & Wellness* for all the cost of such efforts, including, but not limited to all court cost and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of *Dr. Goff's Chiropractic & Wellness* and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the rights and interests of *Dr. Goff's Chiropractic & Wellness* and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Printed Name of PATIENT	Signature of PATIENT or PARENT/GUARDIAN	Date