Dr. Aaron T. Halle • Chiropractic Physician
1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

Welcome to our office! *Thank you for choosing us as your chiropractic provider. Please complete the following information.*

PATIENT INFORMATION

I am a/an: ☐ New patient ☐ Existing patient/providing updated information

Legal name: _____ SSN: _____ Preferred name: _____

Birth date: _____ Age: _____ ☐ Male ☐ Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

Are you: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Prefer not to indicate

Health complaints/reasons for consulting this office: _____

Is this due to a: ☐ Work-related injury ☐ Vehicle accident/injury

Whom may we thank for referring you? _____

Please indicate whom we could contact in case of an emergency:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

FINANCIAL INFORMATION

Legal name of person responsible for this account: _____ Relationship to patient: _____

SSN: _____ ☐ Male ☐ Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Legal name of insured: _____ Relationship to patient: _____

Insured's birth date: _____ SSN or Member ID No.: _____ Group No.: _____

Insurance company: _____ Insurance phone: _____

Insured's employer: _____ Work phone: _____

Employer address: _____ City, State, Zip: _____

Please indicate any secondary insurance you have: _____ Please tell me more about this ☐ Yes ☐ No

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, and/or the individual that has appointed me as their legal representative or guardian (hereafter "I"), ever have a change in health, insurance, and or benefits. By signing this form, I certify I have insurance coverage with the above-named insurance company(ies), authorize the use of my signature on all insurance submissions, and assign directly to Daron Halle Chiropractic all insurance benefits payable for services rendered. I also hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical condition(s), accident(s), injury(ies), illness(es), past or future condition, to pay directly to and exclusively in the name of Halle Chiropractic LLC, such sums as may be owing for charges incurred by me for any and all service(s) rendered. Whether or not reimbursed by any or all of these entities, I understand that I am financially responsible for all charges.

Dr. Halle may use my healthcare information and may disclose such information to the above-referenced payers and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

_____ _____

Signature of patient, parent, or legal representative/guardian Date

_____ _____

Printed name of patient, parent, or legal representative/guardian Relationship to patient

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PATIENT HEALTH HISTORY

Patient name (please print):_____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD AND HOW OFTEN IT OCCURRED:

OCCASIONAL	FREQUENT	CONSTANT	MUSCLE & JOINT
			Arthritis
			Bursitis
			Carpal tunnel
			Foot trouble
			Hernia
			Low back pain
			Neck pain or stiffness
			Pain between shoulders
			Pain or numbness in:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Legs
			Knees
			Feet
			Tail bone
			Poor posture
			Sciatica
			Spinal curvature (scoliosis)
			Swollen joints

OCCASIONAL	FREQUENT	CONSTANT	GENERAL
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Loss of sleep
			Nervousness/depression
			Neuralgia (nerve pain)
			Numbness
			Sweats
			Tremors
			Weight loss

OCCASIONAL	FREQUENT	CONSTANT	WOMEN
			Congested breasts
			Cramps or backache
			Excessive menstrual flow
			Hot flashes
			Irregular cycle
			Menopausal symptoms
			Painful menstruation
			Vaginal discharge
			Pregnant? ☐ Yes ☐ No

OCCASIONAL	FREQUENT	CONSTANT	EYES, EARS, NOSE, & THROAT
			Asthma
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Earache
			Ear discharge
			Ear noises
			Enlarged glands
			Enlarged thyroid
			Eye pain
			Failing vision
			Farsighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Nearsighted
			Nose bleeds
			Sinus infection
			Sore throat
			Tonsillitis

OCCASIONAL	FREQUENT	CONSTANT	GASTROINTESTINAL
			Belching or gas
			Colitis
			Colon trouble
			Constipation
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Excessive hunger
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Liver trouble
			Nausea
			Pain over stomach
			Poor appetite
			Vomiting
			Vomiting of blood

OCCASIONAL	FREQUENT	CONSTANT	CARDIOVASCULAR
			Hardening of arteries
			High blood pressure
			Low blood pressure
			Pain over heart
			Poor circulation
			Rapid heart beat
			Slow heart beat
			Swelling of ankles

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PATIENT HEALTH HISTORY (*continued*)

Occasional	Frequent	Constant	Genitourinary
			Bed wetting
			Blood in urine
			Frequent urination
			Inability to control kidneys
			Kidney infection or stones
			Painful urination
			Prostate trouble
			Pus in urine

Occasional	Frequent	Constant	Respiratory
			Chest pain
			Chronic cough
			Difficult breathing
			Spitting up blood
			Spitting up phlegm
			Wheezing
Occasional	**Frequent**	**Constant**	**Skin**
			Boils
			Bruise easily
			Dryness
			Hives or allergy
			Itching
			Skin eruptions (rash)
			Varicose veins

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism ☐ Anemia ☐ Appendicitis ☐ Arteriosclerosis ☐ Arthritis ☐ Cancer ☐ Other, please list:
☐ Chorea ☐ Cold sores ☐ Diabetes ☐ Diphtheria ☐ Eczema ☐ Emphysema
☐ Epilepsy ☐ Fever blisters ☐ Gout ☐ Heart disease ☐ HIV/AIDS ☐ Influenza
☐ Malaria ☐ Measles ☐ Miscarriage(s) ☐ Multiple sclerosis ☐ Mumps ☐ Parkinson's
☐ Pleurisy ☐ Pneumonia ☐ Polio ☐ Rheumatic fever ☐ Scarlet fever ☐ Stroke
☐ Thyroid ☐ Tuberculosis ☐ Typhoid fever ☐ Ulcers ☐ Venereal disease ☐ Whooping cough

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever had previous chiropractic care? ☐ Yes ☐ No If yes, date of last care and doctor name or location:_____

What is your major complaint? _____

Other complaints?_____

How long have you had these complaints?_____ Have you had these or similar complaints in the past? ☐ Yes ☐ No

What activities aggravate your complaints? ☐ Coughing ☐ Sneezing ☐ Reaching ☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Walking

☐ Other, please describe:_____

Are these complaints getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Are these complaints interfering with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Other, please describe_____

Are your complaints the result of an ☐ On the job accident ☐ Auto accident ☐ Other, please describe_____

Was the accident within: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Briefly describe your accident:_____

Please list previous diagnoses and treatments you've received for these complaints:_____

_____

How long has it been since you've felt good?_____ What do you believe is wrong?_____

Please list surgical operations and years:_____

Please list drugs you currently take:_____

Age of mattress:_____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? ☐ Yes ☐ No

Age of pillow:_____ ☐ Comfortable ☐ Uncomfortable Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports (orthotics)

HAVE YOU EVER:

Been knocked unconscious? ☐ Yes ☐ No Describe:_____
Used a crane, crutch, or other support? ☐ Yes ☐ No Describe:_____
Been treated for a spine or nerve disorder? ☐ Yes ☐ No Describe:_____
Had a fractured bone? ☐ Yes ☐ No Describe:_____
Been hospitalized for other than surgery? ☐ Yes ☐ No Describe:_____

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PATIENT HEALTH HISTORY (*continued*)

DO YOU:

Now take vitamins or minerals? ☐ Yes ☐ No Describe:_____
Think you may need vitamins or minerals? ☐ Yes ☐ No Describe:_____
Have an allergy to any drug? ☐ Yes ☐ No Describe:_____

APPROXIMATE DATE OF LAST:	**Less than 6 months**	**6–18 months**	**Over 18 months**	**Never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

List below all conditions for which you have been treated in the past 10 years:

_____
_____
_____
_____
_____
_____

FAMILY HEALTH INFORMATION – Many health problems are the result of hereditary spinal weakness; therefore, information about your family members will give the doctor a better understanding of your current health status.

Relation:_____ Past health problems:_____ Present health problems: _____
Relation:_____ Past health problems:_____ Present health problems: _____
Relation:_____ Past health problems:_____ Present health problems: _____

_____ _____
Signature of patient, parent, or legal representative/guardian Date

_____ _____
Printed name of patient, parent, or legal representative/guardian Relationship to patient

Halle Chiropractic, LLC

1857 N. Kolb
Tucson, AZ 85715
(520) 290-2229
(520) 290-2236 fax

Date:_____

To:_____

_____

_____

I hereby authorize the release of my x-rays and/or copies of all records and request that they are transferred to:

_____

C/O Halle
1857 N. Kolb Rd.
Tucson, AZ 85715
(520) 290-2229
(520) 290-2236 fax

_____

Patient Name (please print)

_____

Patient Signature

DOB:_____

SS#_____

HIPAA Compliant Patient Authorization

This authorization is requested in order to meet federal and state privacy guidelines. By signing you are giving the doctors and staff permission to use your personal information and health information for the areas outlined below. This information is being requested so that we can better meet your health care needs. However, should you decline to authorize any of the items listed, it will not affect the treatment that we provide to you. You may also put certain limitations on the use of your information. This must be done in writing. You are not required to sign this form, but rather are only requested to do so.

You have the right to inspect your records at any time. You also have the right to change the authorizations previously given at any time. All requests must be in writing. Please allow a reasonable time for our clinic to carry out your request.

Please refer to our "Privacy Manual" in our waiting room for details on the extensive measures we have taken to protect your personal information. If you feel that we are not meeting those policies of have any suggestions on how we need to amend those policies, please share your feelings with one of our staff members.

Your personal information will never be given to any group or individual for purposes of advertising or referrals outside of this clinic. It will only be used by our staff and only regarding your health care.

Please initial next to each area and sign below:

Accept _____ **Decline** _____	**It is okay to call me at home and leave a message on answering machine or with someone at my home.**
Accept _____ **Decline** _____	**It is okay to call my work and leave a message if I am not there.**
Accept _____ **Decline** _____	**It is okay to mail newsletters and special announcements to my home. (only correspondences from Halle Chiropractic).**
Accept _____ **Decline** _____	**It is okay to use my name to patients that I refer and to mail a thank you card for referrals using my name.**

I authorize the staff and Dr. Halle at Halle Chiropractic to use my personal and health information as outlined above and in their Privacy Manual.

_____	_____	_____
Print Name	**Signature**	**Date**

_____

Witness Signature

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POLICIES AND PROCEDURES FOR OUR PATIENTS

Patient name (please print):_____

Welcome to our office! *We hope these policies and procedures help prevent any misunderstandings. Please let us know if you have any questions.*

Clinic hours

Our office is open Monday through Friday for your convenience. Appointments are available at many times of the day including early mornings, during lunch, and early evenings. To better serve you, and to ensure you stay on track with your treatment plan, please schedule your future appointment(s) before leaving the office.

Appointments

A certain number of adjustments in a given time period is necessary to get the best results from your care. While we can't predict the exact number of adjustments you will need, we do know that consistency with your treatment plan creates the best results. Therefore, it is absolutely necessary that you keep your appointments so you stay on target for wellness. If you need to change an appointment, a 24-hour advance notice must be provided to the office. Please note that any massage appointment missed without a 24-hour notice will be subject to a $50 charge.

All missed appointments must be made up within the same week so that you stay on track with your treatment plan. Deviating from your treatment plan will interfere with healing and progress, so please do your best to maintain your appointments. If you haven't notified us to reschedule a missed appointment, we will contact you because keeping you on track matters to us.

We will regretfully dismiss you from care if appointments are repeatedly missed. As stated earlier, missing your appointments will not only interfere with the corrective process of your care, but will interfere with Dr. Halle's ability to provide care to other patients.

Visit procedure

Each time you arrive for your visit, you are required to fill out a sign-in sheet. Any of our staff members are available to assist you with this sheet if necessary. The sign-in sheet allows you to illustrate or explain how and what you are feeling in your own words and also allows Dr. Halle to focus on the problem area(s). *Please note that when indicating your pain level on a scale from 1 to 10, it is important that you indicate the worst pain level you've experienced since the time you first started noticing symptoms.* These sign-in sheets are critical because they allow Dr. Halle to evaluate your progress or notice if problems keep recurring. After completing the sheet, please have a seat in the reception area until you are directed to the treatment waiting area or a treatment room. Dr. Halle will examine your problem area(s). Chiropractic treatment will take only a few minutes and may be followed by other necessary therapies as determined by Dr. Halle.

Symptoms

Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected, having good days and bad days is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. *This takes time* and can be a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey. Please notify Dr. Halle immediately of any abnormal symptom(s) you experience.

Communication

Please know that it is Dr. Halle's personal and professional goal to get you to *experience optimal health*. If this is also your goal, it is pivotal that you communicate about any change in your health, your progress, provide feedback about treatments and therapies that you are and/or aren't responding to, and inform Dr. Halle about external circumstances or situations that could be hindering your progress. Additionally, Dr. Halle wants to hear from you about how his office is performing or any other concerns that you might have.

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Nutritional and health aids

Our office offers a wide array of nutritional aids such as vitamins, supplements, medical food, and essential oils. Health aids such as mattresses, custom orthotics, pillows, ice packs, TENS units, etc. are also offered. Dr. Halle has contracted with top chiropractic suppliers and vendors to make the best yet most reasonably priced products available to you. While we may not have something on-hand, we can special order any item that is necessary for your care. Please consult with Dr. Halle prior to any requests or purchases to ensure you are getting the proper aids so there is no interference with your healing and progress. Please note these products are subject to applicable sales taxes and are non-refundable.

Financial responsibility and arrangements

We are committed to providing you the best chiropractic care possible and hope to help you achieve the level of health that you desire. In order to do that, we need your assistance by understanding the following:

- Payment for services provided is expected at the time they are rendered, unless other arrangements are authorized by our office. We accept all major credit cards, personal checks, money orders, cashier's checks, and cash. Credit and debit transactions are subject to a $1.00 surcharge; however, flex or health reimbursement credit cards are excluded from this surcharge.
- If you have health insurance, a personal injury claim, or workers compensation claim, we will submit your claim(s) to the appropriate party as a courtesy for you. We will gladly attempt to answer your questions relating to this claim; however, you must realize that:
  - You are responsible to inform our office about a change in insurance, benefits, at-fault party information, etc.
  - Not all services are a covered benefit or will be paid by a claim. In some instances we have found that insurance companies will deny or reduce benefits or claims despite our best efforts to demonstrate the necessity for the care provided.
  - Your health insurance coverage is based on a contract between you and that company—we are <u>not</u> a party to that contract. Therefore, all charges, whether or not paid by insurance, at-fault party, etc., are ultimately your financial responsibility.
  - If in the event full payment for services provided isn't made through settlement of a claim, you are responsible for making a full payment on any outstanding balance on your account. We must emphasize that as a health care provider, our relationship is with you, <u>not</u> with the claim payer.
- Personal checks returned for insufficient funds will be subject to the charges imposed on our office by the financial institution.
- Any outstanding balance over 60 days is charged interest at one-and-one-half percent (1.5%) per month.
- Any outstanding balance over 90 days is subject to collection by an outside agency. You will be responsible for paying your outstanding balance, the accrued monthly interest, all collection fees, and any other fees incurred as a result of the collection effort.
- Payment arrangements are available but they need to be established at the time of or before care is initiated.
- If your insurance doesn't offer chiropractic benefits, please speak with our office. Every attempt will be made to provide affordable chiropractic care.

I have read, or have had read to me, the above policies and procedures. I have also had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that these policies and procedures are not intended to be all-inclusive and other matters may arise that aren't discussed here. By signing below, I state that I agree to comply with stated or implied policies and procedures.

Signature of patient, parent, or legal representative/guardian	Date
Printed name of patient, parent, or legal representative/guardian	Relationship to patient

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INFORMED CONSENT

Patient name (please print):_____

I hereby request and provide consent for Halle Chiropractic LLC (Dr. Halle) to perform chiropractic manipulation and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me or on the patient named below, for whom I am the parent or am legally responsible.

I understand that chiropractic manipulation is a specific adjustment for subluxation, that is, a joint that has lost its ability to move and function properly. Abnormal movement patterns and improper function will continue and may negatively impact nerve activity unless corrected. In order to correct this, I understand that Dr. Halle will use his hands or the necessary instruments to move joints within the affected area. The movement of joints can create an audible "pop" or "click." This is caused by gasses within the joint being released when it is adjusted.

I understand and am informed that, as in the practice of medicine, there are some risks to treatment in the practice of chiropractic. These risks can include but are not limited to fractures, disk injuries, dislocations, and sprains. These are rare and can result from an underlying weakness in or illness associated with the bones. Another risk is stroke; however, the chances for stroke are far rarer. A scientific study stated there is a 1 in 5.58 million chance for a stroke to be caused by a chiropractic adjustment (Haldeman et al, 1999). Despite the rarity of these risks, we conduct examinations and tests to identify if you may be susceptible to an injury or if an existing injury exists that would lead to health complications.

Other chiropractic procedures involve physiotherapy such as electrical muscle stimulation, traction, decompression, ultrasound, infrasound, application of cold and/or hot packs, exercises, stretching protocols, gait modification, and/or balancing. I understand these procedures may result in muscle strain, muscle spasms, ligament sprain, burns, dizziness, and other symptoms.

I do not expect Dr. Halle to be able to anticipate and explain all risks and complications. I wish to rely upon Dr. Halle to exercise judgment during the course of the procedure(s) which he feels at the time is/are in my best interest. I understand that Dr. Halle's judgment is based upon the facts known to him professionally as well as those that I have personally disclosed to him. I understand the importance of disclosing all medical information to Dr. Halle so I can be treated appropriately. I will notify Dr. Halle immediately to explain any negative symptoms so a necessary evaluation may be performed and corrective actions may be employed.

I have had an opportunity to discuss the nature and purpose of chiropractic manipulation and other procedures with Dr. Halle. I understand that 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 and have had my questions answered satisfactorily. 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. By signing below, I state that I have weighed the risks involved with recommended treatment and have decided it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to undergo the recommended treatment.

Signature of patient, parent, or legal representative/guardian	Date
Printed name of patient, parent, or legal representative/guardian	Relationship to patient

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NOTICE OF PRIVACY PRACTICES

Patient name (please print):_____

All health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Call you on your mobile, at home, or place of business to remind you of scheduled or missed appointments
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation
- Discussing your claim(s)

You have the right to:

- Request a copy of your health record
- Request with whom we share your health information
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your health information

Consultation and Exam

To begin today's visit, we will collect confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests. If we believe we may help you, we will recommend a complete examination so we can thoroughly evaluate your condition. We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of findings from the recorded history, consultation, and examination. If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan will be developed to address your short-term and/or long-term goals. As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy.
- I understand any questions can be directed to clinic management.
- I understand the purpose of today's visit.
- The doctor(s), employees, or designated agents of this clinic may use my protected health information in the manner previously described.

_____ _____

Signature of patient, parent, or legal representative/guardian | Date

_____ _____

Printed name of patient, parent, or legal representative/guardian | Relationship to patient

Halle Chiropractic, LLC

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Heart Rate _____

AUTO ACCIDENT FORM

one

ABOUT YOU

Name: _____

Date: _____

two

DETAILS OF ACCIDENT

Date and time of accident: _____

In your words, please describe the accident: _____

_____

_____

_____

If a traffic violation was issued, what was the citation issued for and to whom was it issued? _____

Names of other people in your vehicle? _____

_____

Did the police come to the accident site? _____ ❑ Yes ❑ No

Was a police report filed? _____ ❑ Yes ❑ No

Were there any witnesses? _____ ❑ Yes ❑ No

Were you wearing a seatbelt? _____ ❑ Yes ❑ No

Were you wearing a shoulder belt? _____ ❑ Yes ❑ No

Was this vehicle equipped with airbags? _____ ❑ Yes ❑ No

If yes, did it/they inflate? _____ ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest?

❑ Above ❑ Below ❑ At base of skull

Were you trying to restrain or grab another person?

❑ Yes ❑ No

Did any part of your body strike anything in the vehicle?

❑ Yes ❑ No

If yes, please describe _____

_____

Did the impact to your vehicle come from the:

❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ Aware or ❑ Surprised by the impact?

Were you braced for the impact? _____ ❑ Yes ❑ No

What was the approximate speed of your vehicle? _____

What was the speed of the other vehicle? _____

three

AFTER INJURY

Did accident render you unconscious? _____ ❑ Yes ❑ No

If yes, for how long? _____

Please describe your symptoms immediately after the accident: _____

_____

_____

Have you gone to a hospital or seen any other doctor? _____ ❑ Yes ❑ No

When did you go? _____

How did you get there? _____ ❑ Ambulance or ❑ Private transportation

Name of hospital and/or attending doctor? _____

_____

Was he/she a _____ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were X-rays taken? _____ ❑ Yes ❑ No

Was medication prescribed? _____ ❑ Yes ❑ No

What recommendations were made? _____

_____

Did you receive any broken bones or bleeding cuts? _____ ❑ Yes ❑ No

If so, explain _____

Have you been able to work since this injury? _____ ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? _____ ❑ Yes ❑ No

If yes, explain _____

Indicate the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty Sleeping	❑ Jaw Problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder Pain	❑ Back Pain
❑ Headache/s	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower Back Pain
❑ Blurred Vision	❑ Tension	❑ Chest Pain	❑ Back Stiffness
❑ Buzzing in Ear	❑ Neck Pain	❑ Shortness of Breath	❑ Leg Pain
❑ Ears Ringing	❑ Neck Stiff	❑ Stomach Upset	❑ Numb Feet/Toes
❑ Other			

Is your condition getting worse? _____ ❑ Yes ❑ No

Is your condition _____ ❑ Constant ❑ Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful even if only sometimes
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Were any of the above symptoms present just prior to accident? _____ ❑ Yes ❑ No

Do you feel these symptoms are a result of this accident: _____ ❑ Yes ❑ No

Have you retained an attorney: _____ ❑ Yes ❑ No

If yes, whom: _____

His/Her phone # _____

VEHICLE YOU WERE IN

Were you the: ---------- ❑ Driver ❑ Front Passenger ❑ Rear Passenter

Driver (if other than you): _____ Phone #: _____

Who is vehicle registered to? _____ Phone #: _____

Insurance:

Name of insured: _____ Phone #: _____

Insurance company: _____ Policy #: _____

Address: _____

Adjuster's name: _____ Phone #: _____

OTHER VEHICLE

Driver: _____ Phone #: _____

Who is vehicle registered to: _____ Phone #: _____

Insurance:

Name of insured: _____ Phone #: _____

Insurance company: _____ Policy #: _____

Address: _____

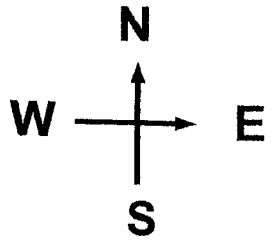
Adjuster's name: _____ Phone #: _____

DIAGRAM ACCIDENT

A A=Your Vehicle

B B=Other Vehicle

C C=Other Vehicle



Street Name

Street Name

Halle Chiropractic
1857 N KOLB
TUCSON, AZ 85715

DATE

NAME

I YOUR INSURANCE COMPANY

NAME OF POLICY

POLICY NUMBER

AGENTS NAME

ADDRESS

PHONE NUMBER

MED PAY COVERAGE YES NO

CLAIM #

II RESPONSIBLE PARTY'S INSURANCE COMPANY

POLICY HOLDER'S NAME

POLICY NUMBER

CLAIM NUMBER

AGENT'S NAME

ADJUSTER NAME

ADDRESS

CITY/STATE /ZIP

PHONE NUMBER

III NAME OF YOUR ATTORNEY

ADDRESS

CITY/STATE /ZIP

PHONE NUMBER

ADVANTAGE
MEDICAL SUPPLY
8902 E. 39th St.
Tucson, AZ 85730
520-750-7555 FAX: 520-750-1754

INVOICE

DATE

INVOICE # **6800**

BILL TO:

Halle Chiropractic
1857 N. Kolb Rd.
Tucson, Az 85715
520-290-2229

SHIP TO:

Halle Chiropractic
1857 N. Kolb Rd.
Tucson, Az 85715
520-290-2229

TERMS	REP	SHIP	VIA	P.O. #	PROJECT
DUE NET 30 ...	RON	3/13/2012	COURIER		

QTY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
1	6012-EA	Ice-Pack 6"x12" Cold or Hot Reuseable 1/EA	15.00	15.00T

Thank you for your business.

Sales Tax (9.1%)	$1.37
Total	**$16.37**

CUSTOMER SIGNATURE: _____

PAYMENT INFORMATION: Reference # Payment Amount:

Dr. Aaron T. Halle
Chiropractic Physician

Halle CHIROPRACTIC

1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

In consideration of your undertaking to care for me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

I authorized payment of any medical benefits from my insurance company and or attorney to be paid directly to Dr. Aaron T. Halle, D. C. for any services rendered to me.

_____ _____

Signature **Date**

Backing You Up When You Need It The Most