Welcome to Delp Chiropractic

Thank you for allowing us the opportunity to assist you with your concerns.

Where is the number one concern that brings you in today?

Does that discomfort radiate or move to another area?

(arm, leg, hand, or hip/buttock?) Certain side or area?

On a scale of 1-10. What number can your discomfort go up to?

1 is almost no discomfort and 10 is significant discomfort

How often do you notice any discomfort?

(Not considering the time when you are asleep.)

Constant 75% to 100%___ Frequent 51% to 75%____ Intermittent 26% to 50%____

Occasional 0% to 25%_____

When did you first notice this issue?

Days, weeks, months, years? _____

What is this concern keeping you from doing to enjoy your life?

Playing with kids or grandkids, work a full day comfortably, etc.

Patient Name_____ **DOB**_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please Answer All Questions Completely

Name_____ Date_____
Sex____ Marital Status_____ Date of Birth_____ Home Phone_____
Social Sec#_____ Cell Phone_____
Cell Phone Carrier (For Appointment Reminders) _____
Email_____ Address_____
City_____ State_____ Zip_____
Occupation_____ Employer_____
Please explain in detail how your accident happened _____
_____
Driver of other vehicle (if any) _____ Date of Birth_____
Their Insurance Company_____ Phone#_____
Policy No._____ Claim No_____
Name of driver of vehicle in which you were injured (self or other) _____
Insurance Company_____ Phone#_____
Policy No._____ Claim No._____
Name of any adjusters who have contacted you_____
Have you retained an attorney? Yes_____ NO _____ Not yet_____
If so, his/her name, address & phone #_____
Give time and date present injury occurred_____
You were struck from? Behind_____ Front_____ Left Side_____ Right Side_____
You were? Driver_____ Passenger_____ Front Seat_____ Back Seat_____ Using Seat Belts_____ Other protective Devices_____
Was anyone else in the vehicle with you at the time of the accident? _____
If yes, we will be happy to get them scheduled for an evaluation.
Did you feel pain immediately after the accident? Yes_____ No_____ Later that Day _____
Next Day_____ When_____
What is your current complaint? _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was treatment given? _____
Was any doctor consulted after the accident? Yes____ No_____
If so give doctor's name _____
Doctor's Diagnosis _____
What treatment was given? _____
How many times have you seen the doctor? _____
Are you still treating with the other doctor? _____
Have you ever had any complaints in the involved area before? Yes_____ No_____
If so, what were the complaints? _____
Are your work activities restricted because of this accident? Yes____ No_____
Since the injury, are your symptoms- Improving ____ Getting Worse _____ The same_____
The doctor may decide to do x-rays in our office.
Is there any chance you could be pregnant? YES____ NO____
Who is your primary care physician? _____
Who can we thank for referring you to our office? _____

Patient Name_____

Describe the reason for your visit? _____

When did your symptoms begin? _____/_____/_____

Have you ever had this same or a similar condition in the past? _____Yes _____No

How does your pain feel? (circle) sharp achy dull deep stinging burning numb tingling crawling stabbing

Does the pain radiate to any part of your body? ____Yes ____NO If so, Where? _____

If you are female, when was your most recent menstrual cycle? _____/_____/_____

Is there any chance you could be pregnant? _____Yes _____No

Which word best describes the frequency of your symptoms? (select one)

_____ Constant (75% to 100% of awake time)
_____ Frequent (51% to 75% of awake time)
_____ Intermittent (26% to 50% of awake time)
_____ Occasional (0% to 25% of awake time)

Which phrases best describe changes in your symptoms during the day?

_____ Worse in the morning
_____ Worse in the afternoon
_____ Worse at night
_____ Changes with the weather
_____ My symptoms do not change

What helps relieve your symptoms?

_____ Ice
_____ Heat
_____ Medication
_____ Nothing Helps
_____ Other

What activities are limited by your symptoms?

_____ Bending
_____ Bowel Movements
_____ Coughing
_____ Daily Routine
_____ Driving
_____ Getting Up
_____ Lifting
_____ Pushing
_____ Reading
_____ Sitting
_____ Sleeping
_____ Sneezing
_____ Standing
_____ Turning my Head
_____ Lying Down
_____ Pulling
_____ Urination
_____ Walking
_____ Working
_____ Other

Please list any surgeries you have had _____

_____

If your injury is due to an accident, please answer the following questions.

What type of accident did you have?
_____Automobile
_____Work related
_____ Other _____

What was the date of the accident? _____/_____/_____

What reports have been filed for this accident?
_____ Police report
_____ Employers report of injury
_____ Other _____

Did you sense the accident coming?
_____Yes
_____No

Immediately following the accident how did you feel?
_____Disoriented or dizzy
_____Nauseous
_____Tightness in your chest
_____Unconscious
_____Other _____

Have you taken time off work due to this accident?
_____Yes
_____No

Are you still off work as a result of this accident?
_____Yes
_____No

Specify Dates: From ____/____/____ To ____/____/____

Were you compensated for time lost from work? _____Yes or ____No

Which best describes your involvement in the accident?
_____Driver
_____Passenger
_____By-Stander
_____Other _____

Was there any one else in the vehicle with you at the time of the accident? _____
If YES, please let them know we would be happy to get the scheduled for an evaluation.

During the Accident:
_____ I was wearing my seatbelt
_____The airbag deployed
_____My vehicle hit another vehicle
_____Another vehicle hit my vehicle

Is there an attorney handling your case? _____Yes or _____No

If yes, please provide the following:

Attorney's name_____
Attorney's phone number (_____) _____-_____

Are there any financially involved parties? _____Yes or _____No

If yes, please provide their:

Name _____
Address _____
Phone Number (_____) _____-_____

Other than your health insurance, are there any other insurance parties involved?
_____Yes
_____No

If yes please provide:

Insurance Name _____
Contact Name _____
Address _____
Phone Number (_____) _____-_____
Fax Number (_____) _____-_____
Claim Number _____

Are there any other details pertaining to the accident that you would like to include?

Release of Records

I, do hereby authorize Delp Chiropractic / Dr. Adam Delp to release my medical and billing records to any of its billing companies, attorneys, adjusters, insurance companies, etc. for the purpose of getting my bills paid.

X_____ ____/____/_____

Permission to Collect on Insurance Checks

I expressly authorize and give permission to Delp Chiropractic / Dr. Adam Delp, and their billing agents, for the signing and completing of any form in the completion of my claims and endorsing any check made payable to me, in support of processing or making payment of claim for any charges incurred by me at these offices. Further, these offices acknowledge that it is only entitled to receive payment for only those charges which were incurred through their office and any overpayment will be refunded appropriately and timely.

X_____ ____/____/_____

Notice of Privacy Practices

I acknowledge that I understand that Delp Chiropractic cannot release my information without proper permission from me and that they will make available a copy of the Privacy Act for my records if I do so request.

X_____ ____/____/_____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible : _____(minor) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. Delp and/or other licensed Physicians of Chiropractic who may treat me now or in the future at his office. I have had an opportunity to discuss with Dr. Delp and /or with other office or clinic personnel in the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including but not limited to, fractures, disc injuries, strokes (CVA), dislocations and sprains, I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to time, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my physician(s) and for any condition(s) for which I seek treatment at this facility.

Print Name X_____ **Sign Name X**_____

Consent for Treatment for Minors

I hereby authorize Dr. Adam Delp (and whomever he may designate as his assistant(s) to administer chiropractic care as he deems necessary to my child named _____.

Guardian's signature_____ ____/____/_____

Witness: _____ Signature:_____ Date: ___/___/_____

Office Policies for Personal Injury Patient

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injurie. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1. Copy of police report and/or copy of the exchange slip.
2. Copy of personal automobile policy. (This is to verify Medical payments covered by your Automobile insurance.
3. Name of individual and insurance company of party that is liable. Please include policy number.
4. Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule any appointment. All appointments that have been missed without notice may be billed to your account.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility and will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

Patient Signature X_____ **Date X**_____

AUTHORIZATION TO RELEASE INFORMATION

Patient _____

Address _____

Date of Birth _____

I authorize any medical, osteopathic, or chiropractic physician, hospital, clinic, rehabilitation facility, or other medical practitioner or provider who has or is or will be furnishing services to me to provide my medical information, including history, treatment, diagnosis and prognosis to Delp Chiropractic.

This ____day of _____, 20___

X_____

Patient Signature

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of (*Delp Chiropractic*) to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to (*Delp Chiropractic*) any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to (*Delp Chiropractic*), from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to (*Delp Chiropractic*) for its services rendered.

I appoint (*Delp Chiropractic*) as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with (*Delp Chiropractic*).

I authorize (*Delp Chiropractic*) to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to (*Delp Chiropractic*) for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If (*Delp Chiropractic*) is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse (*Delp Chiropractic*) for its costs of recovery, including reasonable attorney's fees.

X_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, (*Delp Chiropractic*) hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

(*Delp Chiropractic*) hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S 44-50.1. (*Delp Chiropractic*) agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

(*DELP CHIROPRACTIC*)

By:_____

Delp Chiropractic

954 N. Main St. Mt. Airy NC 27030
(336) 786-5555 Phone
(336) 786-0086 Fax

Adam S. Delp, D.C.

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible : _____(minor) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. Delp and/or other licensed Physicians of Chiropractic who may treat me now or in the future at his office. I have had an opportunity to discuss with Dr. Delp and /or with other office or clinic personnel in the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including but not limited to, fractures, disc injuries, strokes (CVA), dislocations and sprains, I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to time, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my physician(s) and for any condition(s) for which I seek treatment at this facility.

To by completed by the patient:

X_____
Print Patient's Name

X_____
Signature of Patient

To by completed by the patient's representative, If necessary (eg, if the patient is a minor or is physically, or mentally incapacitated).

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Representative