Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separeted ☐ Divorced

Patient employed by _____ Occupation _____

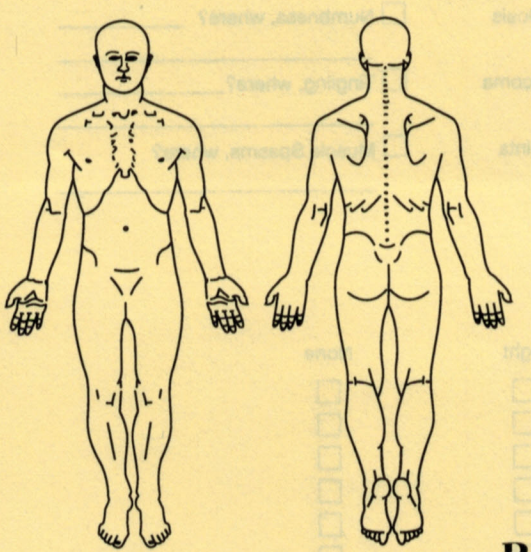
Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Please mark on the diagram the location of the pain.



- Current pain: /10 0 1 2 3 4 5 6 7 8 9 10
- Average pain: /10 0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL DURING:

- Activities of Daily Living: /10 0 1 2 3 4 5 6 7 8 9 10
- Work: /10 0 1 2 3 4 5 6 7 8 9 10
- Sports/Recreation: /10 0 1 2 3 4 5 6 7 8 9 10

When and what makes it better? _____

When and what makes it worse? _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for this visit _____

Please describe your current pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pani? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perfom: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping

☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

HISTORY OF THE ACCIDENT

Name _____

Date of Accident _____ Time _____ a.m. p.m.

Where did accident happen? _____

Describe the accident in your own words in detail: _____

_____

_____

_____

What was your position in car ☐ Driver ☐ Passenger If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your car struck by other vehicles? ☐ Yes ☐ No

Was the impact from ☐ The Front? ☐ From the Right Side? ☐ From the Left Side? ☐ From the Rear?

At the time of impact, were you ☐ Looking straight ahead? ☐ Looking right? ☐ Looking left?

Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Windows ☐ Other _____

Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head ☐ Other _____

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to hospital? ☐ Yes ☐ No

If you went to hospital, when? At time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No

How did you get to hospital? Ambulance ☐ Yes ☐ No Private transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints ☐ Yes ☐ No Brace ☐ Yes ☐ No

Name of Hospital _____

Attended by Doctor _____ Were you x-rayed at hospital ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor ☐ Yes ☐ No See orthopedic doctor ☐ Yes ☐ No Physical Therapy ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's Name _____

Is your pain constant? ☐ Yes ☐ No Is the pain on and off? ☐ Yes ☐ No Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No

Other _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Is your pain worse when arising from a chair? ☐ Yes ☐ No Is it made worse by straining? ☐ Yes ☐ No By coughing ☐ Yes ☐ No

By sneezing? ☐ Yes ☐ No By straining when moving your bowels ☐ Yes ☐ No

Do you have any numbness or tingling in your arms? ☐ Yes ☐ No In your hands? ☐ Yes ☐ No In your fingers? ☐ Yes ☐ No

In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No In your toes? ☐ Yes ☐ No

What is your most comfortable position? Sitting ☐ Yes ☐ No Lying on your right side ☐ Yes ☐ No On your left side ☐ Yes ☐ No

Lying on your back ☐ Yes ☐ No On your stomach ☐ Yes ☐ No Standing ☐ Yes ☐ No

Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve your pain? ☐ Heating Pad ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (if you have tried one) relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in leg? ☐ Yes ☐ No

Do you have cramps in arm? ☐ Yes ☐ No Have you had any change in your bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ to _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination, diagnostic x-rays and physical therapy techniques, on me (of on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licenses doctors of Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as back up for the doctor of Chiropractic named below.

I understand that as with any health care procedures, there are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fractures, disk injuries or dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then, known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the natural purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the Chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Name(s) of Doctor(s) Treating Patient:

James Baranski, D.C.
Advanced Spine & Sport Chiropractic
4601 Telephone Rd., Suite 110
Ventura, CA 93003
(805) 642-4061

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient Date

_____ _____

Witness to Patient's Signature Date

_____ _____

Translated By Date

Privacy Practices Acknowledgement

I have been given the opportunity to review the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Advanced Spine & Sport Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Patient Signature Date

NOTICE OF DOCTOR'S LIEN
(Under California State Insurance Code #10133)
ADVANCED SPINE AND SPORT CHIROPRACTIC
4601 TELEPHONE RD. SUITE 110
VENTURA, CA 93003
Phone: (805) 642-4061 Fax: (805) 642-7295

Patient: _____ **Date of Accident:**_____

I do hereby authorize James Baranski, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to James Baranski, D.C. such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are die his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate James Baranski, D.C. And I hereby further give a lien on my case to James Baranski, D.C. against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to James Baranski, D.C. for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify James Baranski, D.C. of any change or addition of attorney(s) used by in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____
Dated **Patient's Signature**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Dated **Attorney's Signature**

**This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to James Baranski, D.C. for payment.

NOTICE OF DOCTOR'S LIEN
(Under California State Insurance Code #10133)
ADVANCED SPINE AND SPORT CHIROPRACTIC
4601 TELEPHONE RD. SUITE 110
VENTURA, CA 93003
Phone: (805) 642-4061 Fax: (805) 642-7295

Patient: _____ **Date of Accident:**_____

I do hereby authorize James Baranski, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to James Baranski, D.C. such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are die his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate James Baranski, D.C. And I hereby further give a lien on my case to James Baranski, D.C. against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to James Baranski, D.C. for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify James Baranski, D.C. of any change or addition of attorney(s) used by in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____
Dated **Patient's Signature**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Dated **Attorney's Signature**

**This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to James Baranski, D.C. for payment.

ADVANCED Spine & Sport CHIROPRACTIC

THIRD PARTY MEDICAL LIEN

Patient's Name:_____

Social Security Number:_____

Date of Injury:_____

I hereby authorize direct_____Insurance Company, to pay Advanced Spine & Sport Medical Rehabilitation Center Inc. such sums as may be due and owing him for chiropractic/medical services rendered me by reason of the accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further request that payment be made DIRECTLY to say doctor which would be paid by myself, as the result of treatment charges incurred for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement tis made solely for said doctor's protection and in consideration of this awaiting payment. I further understand that such payment is not contingent on my settlement, judgement or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning this to the doctor's office. I have been advice if you not wish to cooperate in protecting the doctor's interest; the doctor will not await payment but may declare the entire balance due and payable to me.

Patient Signature:_____Date:_____

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold sums from any settlement, judgement or verdict, as may necessary to adequately protect and fully compensate said Doctor above-name and make payment directly to said doctor.

Please date, sign and return the original to the Doctor's office. Also keep one copy for your records.

Date: _____

_____

Signature of Insurance Company Representative

_____

Insurance Company Name

4601 Telephone Rd Suite #110, Ventura, CA 93003 * P: (805) 642-4061 * F: (805) 642-7295

ADVANCED Spine & Sport CHIROPRACTIC

FINANCIAL AGREEMENT
PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBILITY:
If you were involved in an auto accident in your own vehicle, we will bill the medical portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MED PAY:
If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

PIP:
If you were a passenger in another vehicle , and you own a car which as PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3RD PARTY: If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be funded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial agreement, if, at any time, you have further questions about your care, please do not hesitate to ask

I have read and agree to the above

_____ _____

Patients Signature **Date**

4601 Telephone Rd Suite #110, Ventura, CA 93003 * P: (805) 642-4061 * F: (805) 642-7295

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currentiy have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

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

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. if there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.