

Auto Injury History Form

Please fill out completely & initial the bottom of each page

For Office Use Only

General Information:

Date of Injury: _____

Approximate time of Injury: _____

Accident History Prior to Crash:

Any previous pain/problems in area injured? (Please answer. If so, explain) _____

Was the accident on the job? Yes No

You were: Driver Front seat passenger
 Rear seat passenger Other: _____

Vehicle driven by: _____

Your vehicle (year, make, model) _____

Your estimated speed at moment of accident: _____
 Stopped Slowing Accelerating

Other vehicle (year, make, model) _____

Other vehicle estimated speed at moment of accident: _____

Road conditions: Dry Damp Wet
 Snow Ice Other _____

Please indicate location of head restraint at the time of the accident:
 At the top of the back of my neck At the middle of the back of my head
 At the bottom of the back of my head At the back of my neck
 Below my neck at shoulders No head restraint
 Head restraint/seat are attached (Integral type)

When you drive how far is your head from the head restraint in inches? _____ Don't know

If adjustable, was the position altered by the accident?
Eg Was it pushed down? Yes No

Was the seat back adjustment altered by the accident?
Eg Did the seat move forward or backwards? Yes No

Do you have your seat reclined when you drive?
 A little Some A lot

Was the seat broken? Yes No

Was your seatbelt broken? Yes No

Lap belt/ Shoulder belt: circle which
 Wearing Not wearing Don't know

Place Patient Id Sticker Here:

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Were you aware of the impending crash? Yes No

If so, how much time prior to impact did you know you would be hit?

Did your air bag deploy? Yes No

If yes, were you struck? Yes No

Body position: Straight Forward lean

Other _____

Head position: Which way were you looking upon impact?

Straight ahead Left ___° Right ___°

Up ___° Down ___°

Hands: One on wheel Two on wheel

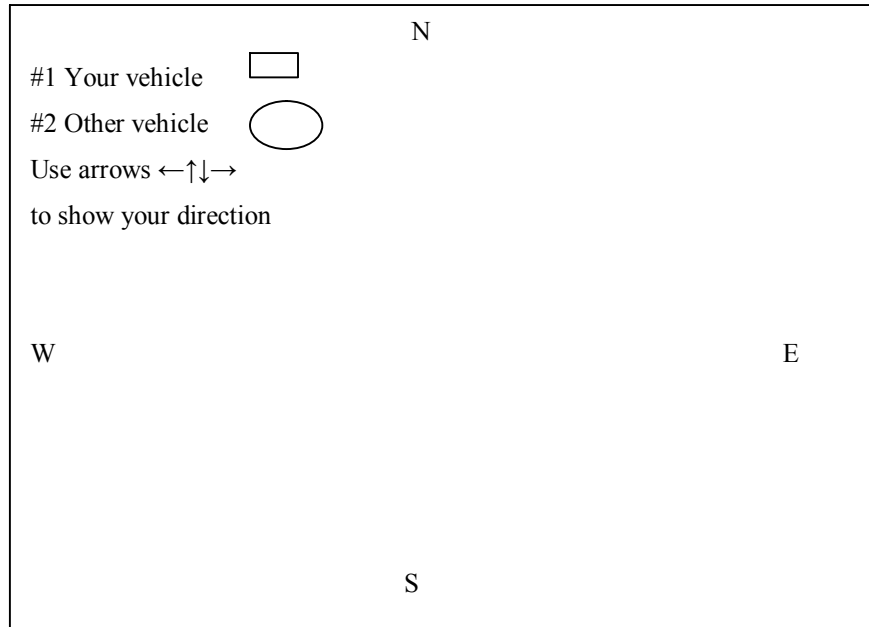
N/A

Brakes applied? Yes No

How soon prior to impact? _____

Brief Accident description: _____

Accident Diagram: Please describe **street names & direction** you were heading. **Draw an "X"** where each vehicle sustained the most damage. A square represents your car (#1) and an oval represents the other car (#2).



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Accident History During the Crash:

Did you strike any parts of the vehicle? Yes No

If yes, describe _____

Did your vehicle strike any objects after crash? Yes No

If yes, describe _____

Wearing hat or glasses? Yes No

If yes, still on after crash? Yes No

Did you lose consciousness? Yes No

If yes, for how long? _____

Please match the body part(s), if any, to the part(s) of the vehicle that were hit during the accident:

Head	Windshield
Face	Steering Wheel
Shoulder	Side Door
Neck	Dashboard
Chest	Car Frame
Hip	Another Occupant
Knee	Seat
Foot	Seat belt

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

Windshield Seat Frame Knee bolster Mirror Dashboard
Steering Wheel Side/rear window

Accident History After the Crash:

Estimated property damage to your vehicle:

\$ _____

Where was your vehicle struck? _____

Estimated damage to other vehicle(s):

None Minimal Moderate Major

Where was the other vehicle struck? _____

Were the police on-scene? Yes No

If yes, was a report made? Yes No

Was alcohol involved? Yes No

If yes, please explain: _____

Symptoms: Headache Dizziness
Nausea Confusion/Disorientation
Neck Pain Back Pain
Arm/ Leg Pain Other _____

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Please describe when you noted each symptom after the crash.

(Eg. Neck pain- immediately, Low back pain- next day) _____

Where did you go after accident? Home Work

Other: _____

Hospital: _____

Mode of transportation: _____

Private Doctor: _____

If you have not seen a doctor for this injury within the first month after accident, please indicate reason(s):

- Did not notice any pain
- Unable to schedule appointment
- I thought the pain would disappear
- I self treated with over-the-counter drugs
- Other _____
- Time conflict
- No transportation
- I had no insurance money
- Took hot showers, used
- Ice/ heat

Have you been unable to work sine the accident? Yes No
If yes, were you off work: partially Please list dates off work:

Accident History Emergency Department:

Did you have any cuts or lacerations? Where? _____

Were you given a neck collar to wear? Yes No X-Rays: Yes No

Body parts imaged _____

Did the doctor give you a diagnosis? Describe: _____

Lab work Yes No

Treatments Performed: _____

Medications: _____

Follow -up instructions: None Other: _____

LEGAL REPRESENTATION

Do you have an attorney yet? Yes No

Who is the attorney handling your injury case?

Name: _____ Phone Number: _____

Address: _____

GENERAL PATIENT CASE HISTORY

Please fill in this questionnaire **COMPLETELY**. If a section does not apply to you, simply cross it out. This confidential history will be part of your permanent records. **Please initial the bottom of each page.**

CHIEF COMPLAINT

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Please be sure to fill in each area completely. Mark the area(s) on your body where you feel the described sensation(s). **Use the appropriate symbol(s).** Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Note diagram on the left is front and on right is the back.

Aches ^^^^ Numbness ooooo

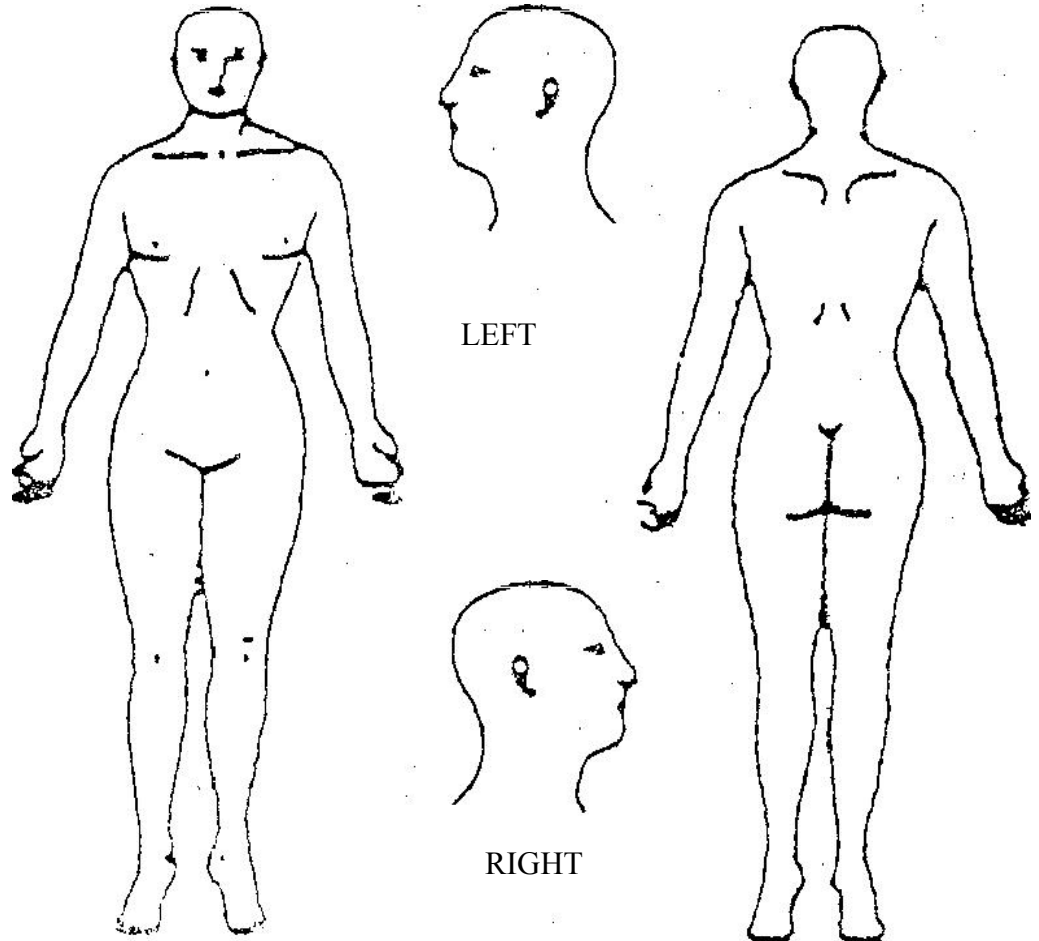
Throbbing TTTTT

Electrical EEEE

Pins/Needles ●●●●

Cramping CCCCC

Burning xxxxx Sharp ////



Patient ID Sticker

What are your major complaints in order of intensity?

What are your major complaints in order of intensity? (#1 most bothersome)	Complaint #1	Complaint #2	Complaint #3
Circle How often is your pain	No pain Occasional Intermittent Constant	No pain Occasional Intermittent Constant	No pain Occasional Intermittent Constant
List for your complaint which movement makes each area worse			
List for your complaint which movement makes each area better			
When during your day are your symptoms worse?			
When during your day are your symptoms better?			
Is this condition _____ (please circle)	Improved Mildly improved Unchanged Mildly Worse Getting Worse	Improved Mildly improved Unchanged Mildly Worse Getting Worse	Improved Mildly improved Unchanged Mildly Worse Getting Worse
On a scale of one-to-ten, how bad are your symptoms now ? (With 1 meaning 'no pain', and 10 meaning 'worst possible pain')			
On a scale of one-to-ten, how bad are your symptoms most of the time ? (With 1 meaning 'no pain', and 10 meaning 'worst possible pain')			
On a scale of one-to-ten, how bad have they been in the past ? (With 1 meaning 'no pain', and 10 meaning 'worst possible pain')			

HISTORY OF PRESENT ILLNESS

What do you think caused this condition? _____

Have you had this or similar conditions in the past? If yes, please explain. _____

How long have you had this condition? _____

Please describe your problem in your own words, including dates when possible. **(Please be as complete as possible.)**

FUNCTIONAL INFORMATION

Has pain interfered with your social life, hobbies or sexual ability? Please draw a line to the match ability level of change.

Social Life	No Change
Hobbies	Minimal Change
Sexual Ability	Considerable Change
	Completely Prevents

How many hours do you sleep at night? _____ Before your pain/injury? _____

Do you know why? _____

Does pain frequently awaken you? Yes No

If yes, about how many times would you wake up per night? _____

Before your pain, how many times would you wake up per night? _____

What is the quality of your mattress? very firm firm semi-firm soft memory foam other _____

Sleep position: Back Stomach Right side Left side

In a typical workday, your job requires that you: (8 hrs total)

Sit ___ hrs Walk ___ hrs Stand ___ hrs Bend ___ hrs

At any one time, how many hours can you:

Sit ___ hrs Walk ___ hrs Stand ___ hrs Bend ___ hrs

Is this condition interfering with: (Please Circle) Work, Sleep or other Daily Routines such as reading, housecleaning, driving, sitting, dressing, etc? Discuss what areas of your body you have more problems with due to each activity.

Are you performing an exercise program? When? How often? _____

ASSOCIATED FACTORS CONTRIBUTING TO BACK OR LEG COMPLAINTS

Is there pain, numbness, or tingling with prolonged standing, walking or climbing stairs in your knees, calves, shins ankles, feet or toes? Yes No

Do you experience aching or cramping in your feet? Yes No

If you wear anything other than your favorite shoes, do you experience these types of symptoms? Yes No

Do you avoid activity due to your pain in your feet or lower extremities? Yes No

Do you have to elevate your feet to get comfortable? Yes No

Are you flat footed? Yes No Have high arches? Yes No Normal arches? Yes No

Do you currently wear custom-made orthotics in your shoes? Yes No Have you before? Yes No

PREVIOUS TREATMENT

PREVIOUS TREATMENT & RESULTS	When ?	Have not had treatment	Significant Benefit	Some Benefit	No Help	Worsened Condition
Physical Therapy						
Chiropractic Manipulation						
Heating pads, ultrasound, whirlpool, massage, etc						
Nerve blocks/ Spinal injections						
Other: _____						
Operations: 1. _____ 2. _____						

If applicable, what have you been told is your diagnosis/ problem? _____

By whom? _____

Who is your primary care provider?

Doctor _____ Clinic Name/Address _____

Last seen _____ Condition _____

Would you like us to refer you to a primary care provider or to a specialist for another condition you have? Yes / No

If yes what condition? _____

What other doctors have you seen in the last 3 years? Please give address if possible.

Doctor _____ Clinic Name/Address _____ Last seen _____ Condition _____

Other Treatments. Please describe: _____

DIAGNOSTIC TESTS

Please tell us what tests have been performed in evaluating your condition.

TEST	Date/ Year	Ordering Physician	Location Performed
X-rays			
CT scan/MRI			
EMG/NCV (Nerve tests)			
Bone Scan/Fluoroscopy			
Other: _____			

PAST INJURY HISTORY

Have you had any prior on-the-job injuries? Yes No Explain: _____

Have you had any automobile accident injuries? Yes No Explain: _____

If disabled, (as worker/ student/ homemaker), date last worked? _____

If disabled, have you tried to return to work? Full time Part time No Yes: What day? _____

Have you received disability income related to this condition? Yes, receive now Yes, in the past No, never

Is this a work related or auto accident injury? Auto Accident Work Accident Neither

PREVIOUS HOSPITALIZATIONS/ INJURIES/SURGERIES

Condition?	When?	Operation (if any):

MEDICATIONS

Please list all the medication that you have been taking recently.

Name of Medication	Dosage	How often
Please list medications you are allergic to:		Type of reaction

REVIEW OF SYSTEMS

Please review the following list of medical problems and mark any that apply to you now or in the past

<u>GENERAL</u>	NOW	PAST		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Arm Weakness	<input type="checkbox"/>	<input type="checkbox"/>
			Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Hand/Wrist Weakness	<input type="checkbox"/>	<input type="checkbox"/>
			Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>			Diabetes Type 1	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 2	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis		
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Deformities		
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>						
Moles	<input type="checkbox"/>	<input type="checkbox"/>	<u>THROAT</u>			<u>GASTROINTESTINAL</u>		
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
			Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEAD</u>			Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<u>NECK</u>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS</u>			Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>				Parasites	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Colostomy	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>
			Pain	<input type="checkbox"/>	<input type="checkbox"/>			
<u>NOSE</u>			Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>				Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Emphazema	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
			Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
<u>BLOOD</u>			Blood w/ Cough	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>				Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART</u>			Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Red Spots On Skin	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood In Urine	<input type="checkbox"/>	<input type="checkbox"/>
			Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>
<u>NEUROLOGIC</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>			
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<u>OTHERS</u>		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Facial Sense	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Angina w/o exertion	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty w/ Speech	<input type="checkbox"/>	<input type="checkbox"/>	Angina w/ exertion	<input type="checkbox"/>	<input type="checkbox"/>			
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			
Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>			
Brain Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Embolism	<input type="checkbox"/>	<input type="checkbox"/>			
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<u>MUSCULOSKELETAL</u>					
<u>ENDOCRINE</u>	NOW	PAST	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>			

FAMILY HISTORY

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illness
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____	_____

► Do you have a family history of spinal/physical problems? (i.e. neck pain, back pain, herniated disc, degenerated disc, sciatica, etc...)

Relation: _____ Condition: _____

RESULTS OF TREATMENT

What are the results you hope for: **(Check all that are apply)**

- Pain reduction Increased recreation Improved emotional well-being
 Return to work Elimination of drugs Better daily function

What other activities would you like for us to help you get back to? _____

What do you hope will be the results of this evaluation: **(Check all that are applicable)**

- Medical diagnosis (discover the cause of the pain) Recommendation for treatment
 Recommendation for rehabilitation Determine the existence of a disability
 Recommendation for surgery
 Other, describe _____

^If you were treated at another office and were dissatisfied with your care, how can we improve on your experience with us? _____

REFERRAL INFORMATION

Who can we thank for referring you?

Patient: _____ Physician: _____ Attorney: _____

Advertisement: _____ Other: _____

CURRENT TREATMENT INTERESTS

Are you interested in: **(Check all that apply)**

- | | |
|---|---|
| <input type="checkbox"/> DRS Low Back Treatment | <input type="checkbox"/> MCU Neck Pain Therapy |
| <input type="checkbox"/> Chiropractic with Occupational or Physical Therapy | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Aquatic/Pool Therapy | <input type="checkbox"/> Home Exercise Program |
| <input type="checkbox"/> Orthotics (Custom Insoles) | <input type="checkbox"/> Free Spinal Health Care Workshop Classes |

FUTURE TREATMENT INTERESTS

Are you interested in: **(Check all that apply)**

- | | |
|---|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Weight loss programs |
| <input type="checkbox"/> Nutritional programs | <input type="checkbox"/> Ergonomic workstation evaluation/training |
| <input type="checkbox"/> Spa Services | <input type="checkbox"/> Anti-Aging Programs |

RELEASE OF INFORMATION:

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

As a courtesy, we may send your primary care physician reports about your treatment with our office. By signing below, I authorize my records to be sent to my primary care physician and the release of any medical or other information necessary to process my claims. Our office may photograph you on your first visit for identification purposes. Your photograph may be sent to your insurance company with your medical records. Any other use will require your consent.

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).

I understand that rehabilitation medicine occasionally aggravates an existing condition and that this may be possible in respect to my condition. I understand treatments rendered by Better Health Pain & Wellness Centers, LLC are intended to aid in the reduction of my pain and to allow as full a recovery as possible and are not intended to aggravate an existing condition or cause a new one to occur.

I have carefully completed and reviewed this form to the best of my knowledge. **Date:** _____

X

Signature of Patient, Parent or Guardian

Relationship to patient (if not self)