
PLEASE COMPLETE THE ATTACHED FORMS AND BRING THEM WITH YOU (ALONG WITH THIS COVER SHEET) TO OUR OFFICE. IF YOU ARE UNABLE TO COMPLETE THESE FORMS PRIOR TO YOUR FIRST VISIT, PLEASE ARRIVE 45-MIN EARLY (60 MIN FOR PERSONAL INJURY CASES) TO LEAVE ENOUGH TIME TO FILL OUT PAPERWORK.

Fort Worth Chiropractic Clinic, PLLC
dba My West Fort Worth Chiropractor ("FWCC")
2920 Oak Park Circle, Suite 101, Fort Worth, TX 76109
(817) 924-7243 | Support@MyWestFortWorthChiropractor.com

Patient Name: _____

Parent / Guardian: _____

Appointment Date/Time: _____

OFFICE USE ONLY: *By Initialing below, I certify that I have reviewed the attached medical forms (including without limit Pre-Day-1-Medical-Forms-CORE-FORMS, Modified-Oswestry-Neck-Index-and-FRI, and Informed Consent to Chiropractic Care) populated with specific data and identifying information. I also certify that any hand-written notations added by me were made on the date below.*

Name of Provider: Derek Page, DC Provider's Initials: _____ Date of Initials: ____/____/____

SECTION – PATIENT INFORMATION

Name of Patient: _____ Today's Date: ____/____/____

Patient's Birthday: ____/____/____ Patient's Gender: ____ M ____ F

(If Applicable) Name of Parent / Guardian / Healthcare Representative: _____

CONTACT INFORMATION

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

SECTION – CHIEF COMPLAINT

Name of Patient:: _____

Today's Date: ____/____/____

What is your **CHIEF COMPLAINT**? _____

When did this begin? _____

How did this happen (i.e., car accident, slip or fall, bending and lifting)? _____

Have you received treatment for this current episode? ____ YES ____ NO

If YES, what treatment have you had? _____

Have you ever experienced episodes of this in the past? ____ YES ____ NO

If YES, what treatment have you had? _____

Severity of pain 0 – 10 (0 is no pain at all and 10 is worst possible pain):**CURRENTLY** _____ / 10 Described as: _____at its **WORST** _____ / 10 Described as: _____at its **BEST** _____ / 10 Described as: _____Does the pain **RADIATE** (i.e., down the arm or leg)? ____ YES ____ NO

If YES, please describe: _____

Is your complaint: ____ Improving ____ Getting Worse ____ Staying the Same

What activities make the pain **WORSE** (i.e., sitting, standing, walking. Etc.)? _____What activities make the pain **BETTER** (i.e., rest, stretching, ice. Etc.)? _____

How often do you experience this pain? ____ Daily ____ 1 – 2x/week ____ 3 or more x/week

Are your symptoms: ____ Constant ____ Half of the Day ____ More than Half ____ Less than Half ____ On and Off ____ Random

Time of day your symptoms are worse: ____ Morning ____ Afternoon ____ Evening ____ Not Applicable

What Activity of Daily Living (ADL) is MOST affected? (**CHOOSE ONLY 1**)

____ Lifting ____ Walking ____ Sitting ____ Driving ____ Standing ____ Sleeping ____ Computer Use

How long are you able to do this before pain starts (i.e. 10 minutes) _____

SECTION – REVIEW OF SYSTEMS

Name of Patient:: _____

Today's Date: ____/____/____

Have you had a fever or infection within the last **30 days**? ____ YES ____ NO

If YES, please describe: _____

Past Medical History – Please mark any medical problem you currently have, or have had in the past:

Head, Eyes, Ears, Nose, Mouth or Throat

- ☐ glasses or contact lenses ☐ cataracts ☐ glaucoma ☐ tinnitus ☐ difficulty hearing/deafness ☐ seasonal allergies
- ☐ sinus trouble ☐ TMJ problems ☐ throat / mouth cancer
- ☐ Other: _____

Respiratory

- ☐ asthma ☐ COPD ☐ emphysema ☐ sleep apnea ☐ lung cancer ☐ tuberculosis
- ☐ Other: _____

Cardiovascular

- ☐ High Blood Pressure ☐ high cholesterol ☐ irregular heartbeat / arrhythmia ☐ heart attack ☐ blood clots
- ☐ congenital heart defect ☐ coronary artery disease ☐ excessive / easy bruising ☐ heart murmur / valve disorder
- ☐ palpitations ☐ congestive heart failure
- ☐ Other: _____

Gastrointestinal

- ☐ reflux / GERD ☐ irritable bowel / IBS ☐ Crohn's disease / Ulcerative colitis ☐ colon cancer ☐ stomach cancer
- ☐ liver disease ☐ pancreatitis ☐ ulcer ☐ colon polyps ☐ diverticulitis ☐ leaky gut ☐ hiatal hernia ☐ GI bleed
- ☐ Other: _____

Genitourinary

- ☐ kidney stones ☐ incontinence ☐ urgency ☐ urinary tract infections ☐ painful urination ☐ sexual dysfunction
- ☐ sexually transmitted disease ☐ bladder prolapse ☐ bladder problems
- ☐ Other: _____

Endocrine

- ☐ diabetes ☐ thyroid problems ☐ hypothyroidism ☐ hyperthyroidism ☐ parathyroid problems
- ☐ testosterone deficiency ☐ Hashimoto's disease ☐ pre-diabetes
- ☐ Other: _____

Skin

- ☐ eczema ☐ skin cancer ☐ melanoma ☐ psoriasis ☐ acne

☐ Other: _____

Neurological

- ☐ stroke or TIA ☐ epilepsy or seizures ☐ multiple sclerosis ☐ Parkinson's ☐ cerebral palsy

- ☐ peripheral neuropathy ☐ small fiber disease ☐ brain tumor

☐ Other: _____

Musculoskeletal

- ☐ scoliosis ☐ arthritis in spine ☐ degenerative disc disease ☐ arthritis in other joints ☐ TMJ ☐ rheumatoid arthritis ☐ gout ☐ osteoporosis ☐ osteopenia ☐ osteomyelitis ☐ sciatica ☐ pins/screws/plate – please explain: _____

☐ Other: _____

Mental Health

- ☐ anxiety ☐ depression ☐ bipolar disorder ☐ ADD/ADHD ☐ schizophrenia

☐ Other: _____

Are you currently in counseling? ___ YES ___ NO

Cancer – ANY type, please specify

☐ Please specify: _____

☐ Treatment: _____

Other Medical Conditions NOT Included Above

☐ Please Specify: _____

Women Only: Are you currently pregnant? ___ YES ___ NO

If YES, how far along, or when is your due date? _____

SECTION – PAST, FAMILY AND SOCIAL HISTORY

Name of Patient: _____ Today's Date: ____/____/____

Surgical History: (Please list ALL previous surgery and approximate date, or age, when it was performed)

Hospitalization History: (Please list ALL non-surgical hospitalizations and date, or age, of hospitalizations)

Medications: (Please list ALL prescription medications that you are currently taking)_____

Allergies to Medications: (Please list all medications that cause allergic reaction and associated symptoms)_____

Past Trauma/Accidents resulting in Injuries with approximate dates: (Examples – Car Accidents, Sports Injuries, etc.) _____

Family Medical History: (Please indicate ANY major health condition)

Mother: _____

Father: _____

Siblings: _____

Smoking/Tobacco use: (Please indicate type and frequency)

Cigarettes: _____

Dip: _____

Cigar: _____

Other: _____

Alcohol use: (Please indicate type and frequency)

Type/Frequency: _____

Exercise Habits: (Please indicate type and frequency)

Type/Frequency: _____

SECTION – MODIFIED OSWESTRY / NECK INDEX / FUNCTIONAL RATING INDEX

Name of Patient: _____

Today's Date: ____/____/____

OFFICE USE ONLY – SCORE:

Please mark which MOST CLOSELY DESCRIBES your condition right now

SECTION 1 – PERSONAL CARE <input type="checkbox"/> No pain; no restrictions <input type="checkbox"/> Pain; no restrictions <input type="checkbox"/> Pain; need to go slowly <input type="checkbox"/> Pain; need some assistance <input type="checkbox"/> Pain; need 100% assistance <input type="checkbox"/> Pain; unable to wash or dress due to pain	SECTION 6 – SOCIAL LIFE / RECREATION / HOUSEHOLD <input type="checkbox"/> Can do all activities without pain <input type="checkbox"/> Can do all activities; but causes pain <input type="checkbox"/> Can do most activities; but causes pain <input type="checkbox"/> Can only do some activities due to pain <input type="checkbox"/> Can only do a few activities due to pain <input type="checkbox"/> Cannot do any activities due to pain
SECTION 2 – SLEEPING <input type="checkbox"/> Normal sleep; not disturbed by pain <input type="checkbox"/> Slightly disturbed sleep; less than 1-hour sleepless <input type="checkbox"/> Mildly disturbed sleep; 1-2 hours sleepless <input type="checkbox"/> Moderately disturbed sleep; 2-3 hours sleepless <input type="checkbox"/> Severely disturbed sleep; 3-5 hours sleepless <input type="checkbox"/> Totally disturbed sleep; 5-7 hours sleepless	SECTION 7 – HEADACHES <input type="checkbox"/> I have no headaches at all <input type="checkbox"/> I have 1 or less headaches per week <input type="checkbox"/> I have 1-2 headaches per week <input type="checkbox"/> I have 3-4 headaches per week <input type="checkbox"/> I have 4-5 headaches per week <input type="checkbox"/> I have daily headaches
SECTION 3 – SITTING <input type="checkbox"/> No pain <input type="checkbox"/> Pain; does not increase with time <input type="checkbox"/> Pain; prevents me from sitting more than 1-hour <input type="checkbox"/> Pain, prevents me from sitting more than 30-minutes <input type="checkbox"/> Pain, prevents me from sitting more than 10-minutes <input type="checkbox"/> Pain, prevents me from sitting at all	SECTION 8 – LIFTING <input type="checkbox"/> I can lift as much as I need without pain <input type="checkbox"/> I can lift as much as I need; but causes pain <input type="checkbox"/> I can only lift moderate weight due to pain <input type="checkbox"/> I can only lift light weight due to pain <input type="checkbox"/> I can only lift weight if it is conveniently positioned <input type="checkbox"/> I cannot lift any weight due to pain
SECTION 4 – STANDING <input type="checkbox"/> No pain <input type="checkbox"/> Pain; does not increase with time <input type="checkbox"/> Pain; prevents me from standing more than 1-hour <input type="checkbox"/> Pain, prevents me from standing more than 30-minutes <input type="checkbox"/> Pain, prevents me from standing more than 10-minutes <input type="checkbox"/> Pain, prevents me from standing at all	SECTION 9 – DRIVING / TRAVEL <input type="checkbox"/> No pain <input type="checkbox"/> Pain; does not increase with time <input type="checkbox"/> Pain; prevents me from driving/travel more than 1-hour <input type="checkbox"/> Pain, prevents me from driving/travel more than 30-minutes <input type="checkbox"/> Pain, prevents me from driving/travel more than 10-minutes <input type="checkbox"/> Pain, prevents me from driving/travel at all
SECTION 5 – WALKING <input type="checkbox"/> No pain <input type="checkbox"/> Pain; does not increase with time <input type="checkbox"/> Pain; prevents me from walking more than 1-hour <input type="checkbox"/> Pain, prevents me from walking more than 30-minutes <input type="checkbox"/> Pain, prevents me from walking more than 10-minutes <input type="checkbox"/> Pain, prevents me from walking at all	SECTION 10 – READING / COMPUTER USE <input type="checkbox"/> No pain <input type="checkbox"/> Pain; does not increase with time <input type="checkbox"/> Pain; prevents me from reading/computer use more than 1-hour <input type="checkbox"/> Pain, prevents me from reading/computer use more than 30-min <input type="checkbox"/> Pain, prevents me from reading/computer use more than 10-min <input type="checkbox"/> Pain, prevents me from reading/computer use at all

SECTION – INFORMED CONSENT TO CHIROPRACTIC CARE

Name of Patient: _____

DIRECTIONS: Please read this entire Informed Consent Document prior to signing it. It is important that you understand the information contained in this Document. Please ask questions before you sign if there is anything that is unclear. This Document applies to Care rendered by the Doctors and other Healthcare Staff at our Office.

The nature of the chiropractic adjustment.

The primary treatment used by Doctors of Chiropractic is Spinal Manipulative Therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment.

As part of the analysis, examination, and treatment (“Care”), you are consenting to the following procedures, including but not limited to: Vital Signs, Postural Analysis, Range of Motion Testing, Basic Neurological Testing, Orthopedic Testing, Palpation, Radiographic Studies (including without limit studies performed at the end of your course of Care if deemed necessary or appropriate), Spinal Manipulative Therapy, Massage Therapy, Ultrasound, Hot/Cold Therapy, EMS, Laser Therapy, Spinal Decompression, and others not specifically listed.

The risks inherent in Chiropractic Adjustments.

As with any healthcare procedure, there are certain complications which may arise during Chiropractic Manipulation and Therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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 without limit stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Our Doctors will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctors attention it is your responsibility to inform the Doctors.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by Chiropractic Manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR).

I, the below-signed (see "Person 2" below), hereby request and authorize the Care as set forth above to my minor son/daughter/ward. As of this date, I have the legal right to select and authorize healthcare services for the minor child / ward named below. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize Care should be revoked or modified in any way, I will immediately notify the Office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I, have read, or have had read to me, the above explanation of the Chiropractic Manipulative Therapy / Adjustment and related Care. I have discussed it with the Doctor(s) at the Office and have had my questions answered to my satisfaction. By signing this Informed Consent Document below, I state that I have weighed the risks involved in undergoing Care and have decided that it is in my best interest to undergo the Care as recommended or determined in the Doctors' discretion. Having been informed of the risks, I hereby give my consent to such Care.

Patient's Signature:

Patient Full Name –

____/____/____

Date of Signature

____/____/____

Date of Signature at Office

Person 2's Signature:

Person Full Name –

____/____/____

Date of Signature

____/____/____

Date of Signature at Office

OFFICE USE ONLY:

By signing below, I attest that I thoroughly discussed this Document and Care with the above-referenced individual(s) prior to the time this Document was signed by such individual(s) at the Office.

Provider's Signature:

Provider's Full Name –

____/____/____

Date of Signature at the Office

New PI Patient Chart

Dear Patient:

Please take time to complete all attached information.

One of our goals is to help ensure you receive the care you need at no out-of-pocket* expense to you.

But another goal is to help ensure that when your case settles or is resolved, all of your bills at our office have been properly covered.

We've been successful helping many other patients accomplish these goals, **BUT WE NEED YOUR HELP.**

The more information you can provide us, the greater the chances that we will be able to help you. Accident coverage can be complex.

If you have any questions, please do not hesitate to ask. We are here to help guide you through the process!

Sincerely

Your Clinic PI Admin Team!

Ask for My Business Card!

**Sheila Page
Clinic PI Administrator
817-924-7243**

***I'm here to HELP
GUIDE YOU!***



"New Patient Information Forms"

Patient's Full Name: _____ Today's Date: ____/____/____

Social Security Number: _____ Birth Date: ____/____/____ Age: _____ Gender: __ F __ M __ O

Marital Status: __ Married __ Separated __ Widowed __ Significant Other __ Single

CURRENT ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

How did you hear about us / who referred you to us? _____

If Advertisement (TV, Radio, Etc.), Any Promo Code or Name? _____

If Internet Search, What Query Did You Use? _____

=====

If you are under 18 years of age, who are your legal parents or guardian?

__ Father Date of Birth: ____/____/____ (m) _____ (h) _____

__ Mother Date of Birth: ____/____/____ (m) _____ (h) _____

__ Legal Guardian / Foster Parent Date of Birth: ____/____/____ (m) _____ (h) _____

ANY OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street: _____

City: _____ State: _____ Zip: _____

Your Profession: _____ Your Employer: _____

Your Work Address: _____ Your Work Phone: _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse: _____ Spouse's Date of Birth: ____/____/____

Spouse's Profession: _____ Spouse's Employer: _____

Spouse's Work Address: _____ Spouse's Work Phone: _____

Spouse is a Student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____

Mobile Phone: _____ Home Phone: _____ Email: _____

Full Address of Contact Person: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

Name of Your Primary Care Clinician: _____ Name of PCC's Practice: _____

City / Town Where Primary Care Clinician's Practice is Located: _____

“New Patient Accident Details Form”

Patient's Full Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____

Date of Accident: ____/____/____ Approximate Time of Accident: _____ AM ____ PM

City or town in which accident took place: _____ State: _____

Name of Premises or Specific Location (Road, Intersection, Etc.) Where Accident Took Place: _____

Type of Accident (Check All That Apply): ____ Auto-Related ____ Work-Related ____ Slip & Fall

Briefly Describe How the Accident Took Place: _____

Were you taken to the hospital after the accident? ☐ YES ☐ NO By ambulance or private car? _____

Were you taken to the hospital **immediately** after the accident? ☐ YES ☐ NO

If not, how much time had elapsed before you went to the hospital? _____

Which hospital were you taken to? _____

Have you been X-rayed since the accident? ☐ YES ☐ NO If so, where? _____

Have you received an MRI since the accident? ☐ YES ☐ NO If so, where? _____

If you suffered extensive injuries as a result of the accident, indicate here: ☐ YES, I suffered extensive injuries as a result of the accident

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: ____/____/____ **Name of Attorney in That Case:** _____

Were you a Medicare Patient at the Time? ☐ YES ☐ NO Approximate Date When Case Settled or Was Resolved: ____/____/____

Date of Accident: ____/____/____ **Name of Attorney in That Case:** _____

Were you a Medicare Patient at the Time? ☐ YES ☐ NO Approximate Date When Case Settled or Was Resolved: ____/____/____

Did a police officer show up at the accident and create a police report? ☐ YES ☐ NO

Do you have a copy of the police report? ☐ YES ☐ NO (*please provide our office with a copy*)

Was a ticket or citation issued by a police officer as a result of the accident? ☐ YES ☐ NO Who received the ticket? _____

AUTOMOBILE ACCIDENTS

Do you have any information, including insurance information, concerning the other parties involved in the accident? ☐ YES ☐ NO

Provide details: _____

Have you been contacted by any adjusters regarding your accident? ☐ YES ☐ NO

Adjuster: _____ Insurance Company: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Have you given a statement to this insurance adjuster? ☐ YES ☐ NO

Adjuster: _____ Insurance Company: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Have you given a statement to this insurance adjuster? ☐ YES ☐ NO

Adjuster: _____ Insurance Company: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Have you given a statement to this insurance adjuster? ☐ YES ☐ NO

Did the accident involve a *hit-and-run* driver? ☐ YES ☐ NO Was the Hit-and-Run Vehicle / Driver ever identified? ☐ YES ☐ NO

Provide details: _____

INFO ABOUT THE VEHICLE / DRIVER WHO STRUCK YOU (IF KNOWN)

Driver / Driver's Policy

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Driver: _____

___ The Driver Doesn't Have Insurance According to Driver ___ I Don't Have the Info

Vehicle Owner / Vehicle's Policy (If Not Owned by Patient or Driver)

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Owner of Vehicle: _____

___ The Vehicle Doesn't Have Insurance According to its Occupants ___ I Don't Have the Info

The Vehicle which struck me is/was (select one):

(A) ___ in the business of transporting persons (B) ___ provided by an employer not including "A" (C) ___ neither of these

Examples of (A) include: Commuter vans, taxis, rideshares (e.g., Uber, Lyft), busses, day care shuttles, and school-sponsored shuttles

If (A) or (B) apply, Name of company, organization or employer providing the method of transport: _____

Any Other Info Relating to Any Other Vehicles / Drivers who Struck You? _____

INFO ABOUT YOU ... AND RELATED VEHICLES AND PERSONS

I was ___ the Driver ___ a Passenger ___ a Pedestrian Struck by a Vehicle

Ownership of the Vehicle I was occupying: ___ I own / co-own the Vehicle I was occupying ___ I do NOT own / co-own the Vehicle I was occupying

If you own, what is the name of the auto body shop where your car is being repaired? _____

The Vehicle I was occupying is/was (select one):

(A) ___ in the business of transporting persons (B) ___ provided by an employer not including "A" (C) ___ neither of these

Examples of (A) include: Commuter vans, taxis, rideshares (e.g., Uber, Lyft), busses, day care shuttles, and school-sponsored shuttles

If (A) or (B) apply, Name of company, organization or employer providing the method of transport: _____

Patient's Policy

Insurance Co _____ Insurance Agent: _____ Policy # _____

___ I Don't Have Insurance ___ I Don't Have the Info ___ I Would Prefer Not to Provide at This Time

Driver's Policy (If Driver Different Than Patient)

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Driver: _____

___ The Driver Doesn't Have Insurance According to Driver ___ I Don't Have the Info ___ I Would Prefer Not to Provide at This Time

Vehicle's Policy (If Not Owned by Patient or Driver)

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Owner of Vehicle: _____

___ The Vehicle Doesn't Have Insurance According to its Occupants ___ I Don't Have the Info ___ I Would Prefer Not to Provide at This Time

Resident-Relative Policy. Do you reside with a family member who owns their own vehicle which may be insured under a different auto policy than your own? – Automobile insurance laws in applicable states require this info (check all that apply)

☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Grandparent ☐ Sister / Brother ☐ Child ☐ None

Insurance Co _____ Insurance Agent: _____ Policy # _____

___ I Do Not Reside with a Family Member Who Owns Their Own Vehicle ___ I Don't Have the Info ___ I Would Prefer Not to Provide

Are you, yourself, licensed to drive? ☐ YES ☐ NO *(please provide our office with a copy)*

Was the car which you were occupying at the time of the accident registered? ☐ YES ☐ NO *(please provide our office with a copy)*

Was there any property damage to any of the vehicles as a result of the accident?

☐ the vehicle which struck me ☐ the vehicle which I was occupying ☐ Neither vehicle was damaged

Describe damage: _____

Do you have pictures? ☐ YES ☐ NO *(please provide our office with copies)*

Status of Any Settlement – Check all that apply:

☐ YES ☐ NO I have settled the property damage claim to my vehicle

☐ YES ☐ NO I have received a settlement check associated with my BODILY INJURY claim

IF YOU ANSWERED “YES” TO THE ABOVE QUESTION:

☐ YES, I have cashed the check

☐ NO, I have NOT cashed ANY checks associated with my bodily injury claim

☐ YES ☐ NO I have signed a settlement agreement associated with my bodily injury claim *(if YES, please provide our office with a copy)*

Details: _____

Are you currently represented by an attorney? ☐ YES ☐ NO

If NO, do you wish to retain an attorney at this time? ☐ YES ☐ NO Are you currently seeking an attorney? ☐ YES ☐ NO

If YES, answer these:

Name of Attorney (if you are currently represented): _____

Phone or Town of the Attorney: _____

Do you have a Letter of Representation from the attorney? ☐ YES ☐ NO *(please provide our office with a copy)*

Do you have a Letter of Protection signed by the attorney? ☐ YES ☐ NO *(please provide our office with a copy)*

Fort Worth Chiropractic Clinic, PLLC

Pain Questionnaire

Name: _____

Date: _____

Use the letters below to indicate the type and location of your sensations you are feeling right now:

A: Aches

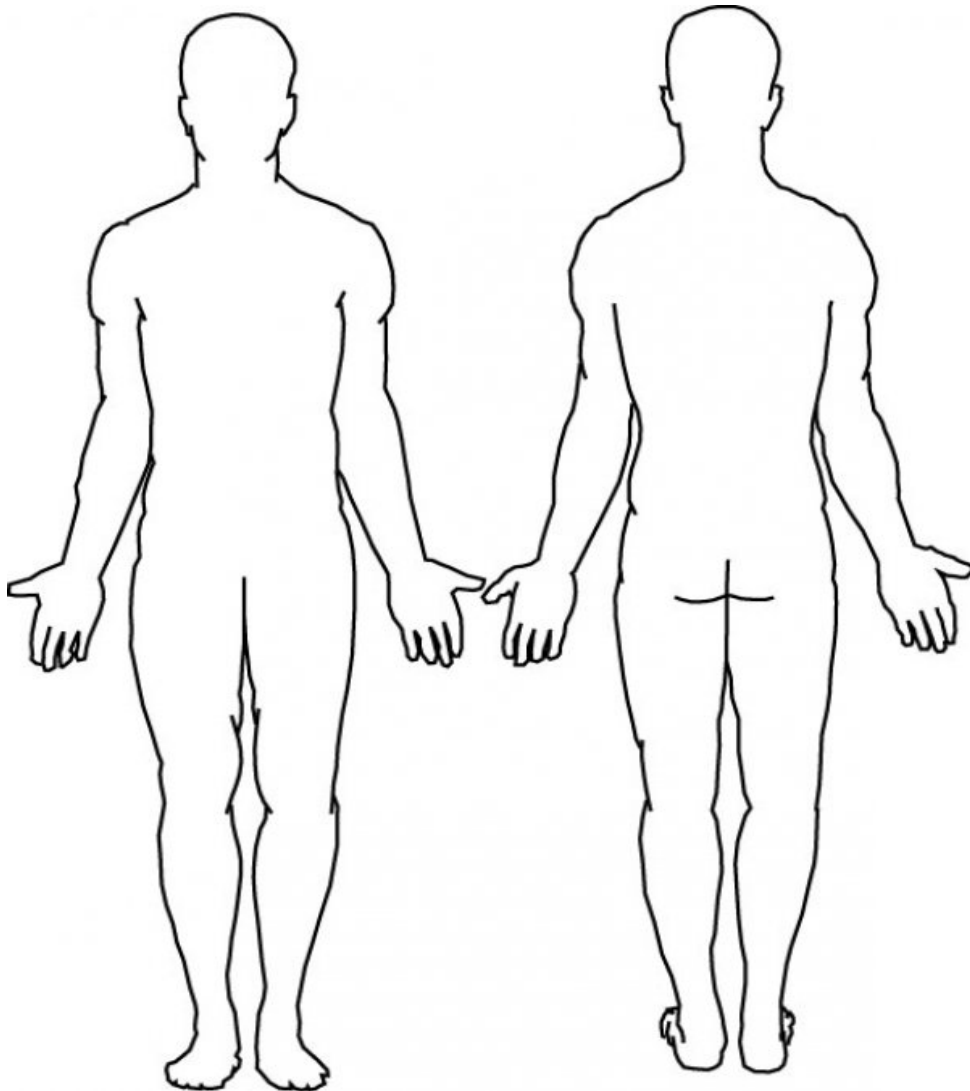
B: Burning

P: Pins & Needles

N: Numbness

S: Stabbing

O: Other



“Gap in Care Form – Initial Gap in Care”

(If There Were More than 2 Weeks Gap in Time Between Accident Date and First Visit)

Version 06 | Last Updated: February 26, 2022

Periodically, we may request that you complete “Gap in Care” forms at our Office. The purpose of the forms is to help us document any notable events or other factors which played a part – or may play a part – in your healthcare decision-making, such as your decision to present to our office when you did, unexpected gaps in care, etc. Payers commonly request this information in conjunction with claims we may submit to them on your behalf.

Patient's Name: _____ Date of Birth: ____/____/____ Date of Accident: ____/____/____

Date / Approx. Date of Your First Visit at **Our** Office Relating to Your Accident: ____/____/____

Date / Approx. Date of Your First Visit at **THE FIRST CLINIC** You Presented for Care Relating to Your Accident: ____/____/____

Initial Gap – Please Describe Reasons for Initial Gap

☐ It wasn't clear whether adjuster was accepting full responsibility

☐ Confused as to the overall process

☐ Didn't know who to see for treatment

☐ Didn't know how medical bills would be paid

☐ Wanted to see if pain would decrease on its own

☐ Pain kept increasing since date of the accident

☐ Was taking pain medications, but condition didn't go away

☐ Was receiving treatment by others

☐ Thought I might lose my job / get demoted

☐ Concerned about treatment interfering with work

☐ Was traveling during the interim

☐ Scared to drive after accident

☐ Had no means of transportation

☐ Other – Describe: _____

Comments:

Patient Signature: _____ Date: ____/____/____

Parent / Guardian Signature: _____ Date: ____/____/____

“Discounts Questionnaire”

1. Administrative Simplification – Open to NOT Filing Claims With Any Insurance Coverages Which May Be Available?

Insurance doesn't necessarily pay for all of your care at our office. As an alternative to filing claims with insurance, we offer very affordable Discounted Payment Plans. In some instances, our Discounted Payment Plans may even cost less than what you have to pay out-of-pocket under insurance rules.

___ Yes, I'm interested in discussing this option and possibly saving a lot of \$\$\$.
Depending on what we discuss, I may opt to have you not file claims with insurance.

___ No, I definitely want for you to file claims with insurance. I want you to file claims with insurance even if it means that what is ultimately owed for care could be greater.

2. Prompt Pay – Open to Paying at the Time of Service or Maybe Even Pre-Paying?

As a general rule, we expect payment at the time of service. Would you prefer to save a substantial amount on what is ultimately owed by paying at the time of service or maybe even pre-paying?

___ Yes, I am interested in saving substantial \$\$\$ by paying at the time of service ... possibly even pre-paying.

___ No, I would prefer to ask that you delay collecting from me at the time of service even though it means that I will lose the benefit of a substantial \$\$\$ savings.

3. Quick Financial Hardship Question

Okay, let's make an assumption together. It's just an assumption. Let's assume that at the end of your care, you were to have a material or substantial balance owing by you at our Office. IF that were to be the case (we're not saying it will be), what is the highest payment you feel you personally would be able to make per month given your present circumstances?

The highest monthly payment I feel I would personally be able to make, or would want to have to make out-of-pocket, assuming the balance at your office was, let's say, \$500 or more, would be:

___ \$25 ___ \$50 ___ \$100 ___ \$200 ___ \$500

Comments:

Name: _____ Signature: _____ Date: ____/____/____

Dear Patient:

Please read the following information. It includes very important auto insurance information for you for your and your family.

Should you have any questions, please feel free to speak with our PI Administrator.

We're here to help
guide you through the process!

Medpay and PIP:

Things You Should Know About These Amazing Auto Insurance Coverages

For More Information, Speak with Our Clinic PI Administrator

Many families have a fantastic form of no-fault insurance coverage on their automobile insurance policies ... *and don't even know it!* This coverage is like health insurance ... but is specifically designed for automobile accident situations.

If you don't have such coverage, we strongly encourage you to look into it as soon as possible. Many people are shocked to learn how inexpensive it is! If you wish, we can recommend some insurance agents who would be happy to evaluate your current insurance policy.¹

Here are some of the many reasons why we encourage you to obtain Medpay / PIP coverage – and to use it – in the event you are injured in an auto accident.

- Medpay is usually very inexpensive.
- Medpay is like health insurance, but better – usually it covers your medical bills 100% up to your coverage limit ... *and just because you use it doesn't mean that your rates will increase.*
- Medpay helps cover you for one of life's most dangerous situations – driving or occupying your car.
- *Medpay will cover your medical bills even if the other at-fault insurance payer will not ... or you are struck by an uninsured or underinsured driver – situations which can and do occur quite frequently.*
- Medpay follows both you AND your car – if you're ever in an accident in someone else's car, your Medpay will still cover you.

For more information, request our brochure on Medpay and PIP.

¹ This resource is subject to the terms of the Uniform Legal Notice located at <http://uln.bpfs.io>. We are not an insurance agent or broker, do not sell insurance, and have no financial interest associated therewith.