**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

Office: (303) 985-0646 Fax: (303) 985-3834

www.abetterbackclinic.com

**Auto Collision / Personal Injury Intake Form**

*(****Fill-in, Circle****, or Mark a* ***✓*** *on each that applies,* ***N/A*** *if does not applicable,* ***Blank*** *if don’t know)*

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender**: [ ] M [ ] F **Marital Status**: [ ]  Single [ ]  Married [ ]  Widowed [ ]  Separated [ ]  Divorced

**Birth Date**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

  **Height** \_\_\_\_\_\_\_\_\_\_ **Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Handed:** RT: \_\_\_ LT: \_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_

**Social Security No**.: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ **Driver’s License No**.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cellular Phone**: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Your Auto’s Insurance Information:**

**Insured’s Name (name the policy is under)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First)

**Relationship to patient (if policy is not under your name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Auto Agents’ Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agent’s phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have Med-Pay coverage?** [ ] Yes [ ] No **Amount of Coverage**? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have under-insured / un-insured coverage?**  [ ] Yes [ ] No

**Have you been issued a Claim# for this accident?** [ ] Yes [ ] No

**Claim#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were you at fault for this accident?** [ ]  Yes [ ]  No

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**Other Party‘s Auto Insurance Information ( If Applicable)**

Other party’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company name of other person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you retained an attorney?**  [ ]  Yes [ ]  No

Your Attorney’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Attorney’s Phone#: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Attorney’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

**Collision Information:**

**Date of Collision:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ **Time of Collision**: \_\_\_\_\_\_\_\_\_\_\_\_ a.m. / p.m.

**The Weather Conditions** were they: [ ]  Sunny [ ]  Raining [ ]  Snowing [ ]  Foggy

**The Road was**: [ ]  Dry [ ]  Wet [ ]  Icy **Light of Day:** [ ]  Dawn [ ]  Day [ ] Dusk [ ]  Night

**Your Vehicle**: Year \_\_\_\_\_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Estimated speed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Collision Type**: [ ] Rear ended [ ] Head-on [ ] Broad-sided [ ]  Side swiped

**Did your car Spin / got Spun?** [ ]  Yes [ ]  No

**Did your car get pushed from the point of impact?** [ ]  Yes [ ]  No (IF Yes, how far Feet\_\_\_\_\_\_\_\_\_\_)

**After being hit did you hit something else?** [ ]  Yes [ ]  No (IF Yes, What\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Car was [ ]  Drivable OR [ ]  Towed away** **Damage to Your Vehicle**: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had your car repaired yet?** [ ]  Yes [ ]  No

(if applicable)

**Other Vehicle**: Year \_\_\_\_\_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Vehicle Damage**: [ ]  Mild [ ]  Moderate [ ]  Severe [ ]  Drivable OR [ ]  Towed away

**Other vehicle’s occupant(s) injured:** [ ]  Yes [ ]  No [ ]  Unsure [ ]  Taken by Ambulance

**Unusual circumstances**: (please note)

(i.e.: was anyone drunk, under the influence, emotionally unstable, speeding, out of control etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Did you take Pictures?** : [ ]  Yes [ ]  No

(If so, of what) [ ]  My car [ ]  Other car(s ) [ ]  Accident scene [ ]  Injured body part(s)

**Collision Specifics**:

**Were you** the: [ ]  Driver [ ]  Passenger

If passenger, where **were you** sitting: [ ]  Front Seat OR [ ]  Back Seat

 [ ]  Right Side OR [ ]  Left Side

**Were you** wearing your seatbelt: [ ]  Yes [ ]  No

**Did the airbag deploy**: [ ]  Yes [ ] No

**Impending Collision, were you**: [ ]  Aware OR [ ]  Unaware

 [ ]  Braced OR [ ]  Not brace

**Right hand:** [ ]  Steering wheel [ ]  Center console [ ]  In Lap [ ]  Door ledge [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_

**Left hand:** [ ]  Steering wheel [ ]  Center console [ ]  In Lap [ ]  Door ledge [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_

**Right foot:** [ ]  Gas [ ]  Brake [ ]  Floor board [ ]  Fire wall [ ]  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Left Foot:** [ ]  Gas [ ]  Brake [ ]  Floor board [ ]  Fire wall [ ]  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head position:** [ ]  Straight ahead [ ]  turned left [ ]  turned right [ ]  bent down [ ]  bent back

**Torso position:** [ ]  Straight ahead [ ]  turned left [ ]  turned right [ ]  bent down [ ]  bent back

**Head rest position:** [ ]  lowest positon [ ]  middle position [ ]  highest position

**Seatback position:** [ ]  straight up-right [ ]  slight recline [ ]  full recline

**Did you feel your body being jarred / jerked?** [ ]  Yes [ ]  No

**Did you feel your seat belt restrain you / engage?** [ ]  Yes [ ]  No

**Any bruising from the seat belt?** [ ]  Yes [ ]  No (If yes, where on your body; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Did any part of your body strike anything inside of your car**: [ ]  Yes [ ]  No

**If Yes** what body part / what area of the car? \_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were any inside parts of your vehicle displaced or broken**: Yes [ ]  No [ ]

If yes list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were any personal items displaced or broken**: Yes [ ]  No [ ]

If yes list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were you able to get out of the car?** Yes [ ]  No [ ]  (if YES Circle) On your own OR Assisted

**Did you experience**: [ ] Shock [ ] Loss of Consciousness [ ] Whiplash [ ]  Dizziness [ ] Other \_\_\_\_\_\_

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**Describe Collision**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Draw a picture / Diagram of collision:**

**Immediate Law Enforcement** following the collision: *(Mark a ✓ on each that applies)*

[ ]  Police were called [ ]  Police showed to the scene

[ ]  No police, we just exchanged information [ ]  Hit & Run, no information to exchange

­­[ ]  I was ticketed for the accident [ ]  Other party was ticketed

[ ]  A Police report was done at the scene [ ]  I filed a police report on my own

[ ]  I have copy of the police report

Police Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Officer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Witnesses:**

Was anyone else in the car with you**:** [ ]  Yes [ ]  No (If yes Who?):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did any other person witness the accident? [ ]  Yes [ ]  No: (if Yes who?):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immediate Medical** **help** following the collision: *(Mark a ✓ on each that applies)*

[ ]  Ambulance / Paramedics were called

[ ]  I was treated at the scene

[ ]  I was transported to Hospital by Ambulance

[ ]  Even though offered transport I opted not to: Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I went to the Hospital (circle) on my own / via friend / via family. When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  (circle) X-rays /Cat scan/ MRI were done at Hospital: What body area:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Medication was prescribed by the Hospital: What; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Follow-up care was recommended: What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Ambulance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FOR THIS CAR COLLISION and before coming to this office, other doctors seen:**

[ ]  Orthopedist [ ]  Neurologist [ ]  Psychiatrist [ ] Physiatrist [ ]  Chiropractor

[ ]  Acupuncturist [ ]  General Practitioner [ ]  Physical Therapist [ ]  Massage Therapist

[ ]  Xray / MRI [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If so give:**

Clinic name Practitioner’s Name Phone number Approximate Date(s) seen \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Symptomatology: (Pain / Complaints) FROM THIS COLLISION, even if only felt momentarily**

**(Muscle – Skeletal):**

**Your Overall Body Picture:**

Please use the legend symbols below to accurately mark the areas in which you feel:

 Stabbing: SSSS Tingling: TTTT Burning: BBBB Cramping: CCCC

 Numbness: NNNN Dull: DDDD Achy: AAAA Pin/ Needles: PPPP



 [ ]  Headaches/ Migraines [ ]  Wrist/ Carpal Tunnel [ ]  Leg/ Calf Pains

 [ ]  Neck Pain [ ]  Inside the Shoulder Pain [ ]  Chest Pain

 [ ]  Top of Shoulder Pain [ ]  Elbow/ Arm Pain [ ]  Abdomen Pain

 [ ]  Mid-Back Pain [ ]  Hand / Fingers Pain [ ]  Problem Sleeping

 [ ]  Along Shoulder Blades [ ]  Hip Pain [ ]  Numbness in Arms/ Hands

 [ ]  Low Back Pain [ ]  Knee Pain **[ ]** Numbness in Legs/ Feet

 [ ]  Sacrum Pain [ ]  Foot/ Ankle/ Toes [ ]  Jaw Pain / clicking

 [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Intensity: None (= 0 on a scale of 0 to 10)

Low (= 1 to 3 on a scale of 0 to 10)

 Moderate (= 4 to 6 on a scale of 0 to 10)

 Intense (= 7 to 9 on a scale of 0 to 10)

 Emergency (= 10 on a scale of 0 to 10)

Timing: Daily (7 out of 7 days a week)

 Random (off and on during the week, yet not every day)

Frequency: Intermittent (Occurs 0 to 25% of the day)

 Occasionally (Occurs 26 to 50% of the day)

 Frequently (Occurs 51 to 75% of the day)

 Constantly (Occurs 76 to 100% of the day)

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Type of Discomfort: Dull Aching Burning

 Tingling Numbness Sharp

 Shooting Throbbing Spasm

Referring: None (Discomfort is contained to the area of compliant)

 Discomfort Radiates to the Left: (body area)

 Discomfort Radiates to the Right: (body area)

 Discomfort Radiates Bilaterally to: (body area)

Aggravated: Upon awakening\*

/ Relieved In the evening\*

 Upon doing; \*

 Brought on by: \*

 Relieved by: \*

 (\*examples Any movement Repeated movement

 Bending (Forward / Backwards) Side Bending (Left / Right)

 Turning (Left / Right) Twisting (Left / Right)

 Sitting Arising Standing Still Walking Lifting Breathing Grabbing Pushing Straining

 Heat/Ice Medication Rest

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**Prioritize Your Symptoms / Conditions**

**(related to prior page and your overall body picture)**

**(1st) First Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(2nd) Second Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(3rd) Third Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(4th) Fourth Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(5th) Fifth Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(6th) Sixth Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(Additional) Body Area/Location/Condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

**(If you have additional body areas/locations, please ask for an additional page)**

**Will be reviewed with your examiner**

**Auto Injury Management**

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**(Cognitive / Emotional/ Sensory):**

***Mark a ✓*** **on symptoms that have resulted DUE TO THIS COLLISION**

***Mark a X* on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION**

[ ]  Ringing in Ear [ ]  Vertigo/ Dizziness [ ]  Loss of Balance [ ]  Fatigued [ ]  Black outs [ ]  Difficulty Concentrating [ ]  Loss of memory [ ]  Vison changes [ ]  Reading Problem [ ]  Sensitivity to Light [ ]  Sensitivity to Sound [ ]  Anxiety [ ]  Highly Emotional [ ]  Irritability [ ]  Apathy [ ]  Depression [ ]  Social withdrawn [ ]  Loss of Taste [ ]  Loss of Smell [ ]  Loss of Hearing [ ]  Difficulty in Speech [ ]  Night mares [ ]  Sensitivity Hot / Cold

[ ]  Loss of Libido [ ]  Thoughts of Suicide [ ]  Typing / Writing Problems

**(Systemic):**

***Mark a ✓*** **on symptoms that have resulted DUE TO THIS COLLISION**

***Mark a X* on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION**

[ ]  Asthma [ ]  Digestive Problems [ ]  Allergies **[ ]** Shortness of Breath [ ]  Extreme Thirst [ ]  Weight Loss /Gain [ ]  Nausea / Vomiting [ ]  Menstrual Irregularities [ ]  High Blood Pressure

**(Miscellaneous):**

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Self-Care:**

**What do you do or have done for yourself to relieve any the symptoms?** (*(Mark a ✓ that applies)*

[ ]  Take Non-Prescription / over the counter Medications

[ ]  Take prescription Medications

[ ]  Recreational drugs

[ ]  Use ice

[ ]  Use heat

[ ]  Get extra Rest / sleep

[ ]  Do Stretches

[ ]  Do Exercises

[ ]  Massage self

[ ]  Massage from family member / friend

[ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Auto Injury Management**

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***Effects of your injuries / symptoms:***

*Please mark a ✓ on each that applies to your activities affected by* ***injuries due to this collision:***

[ ]  Have to hold onto something to sit or stand from a chair.

[ ]  Stay at home most of the time.

[ ]  Have to sit most of the day.

[ ]  Stays in bed most of the day.

[ ]  Change position frequently to try and get comfortable.

[ ]  Have difficulty turning over in bed.

[ ]  Have to lie down and rest frequently.

[ ]  Have to get other people to do things for me.

*Please mark a ✓ on each that applies to Difficulties you are having in your daily activities* ***affected by injuries due to this collision:***

[ ]  Driving the car [ ]  Bathing self [ ]  Going to Restroom [ ]  Climbing Stairs [ ]  Walking [ ]  Dressing Self

[ ]  Brushing teeth [ ]  Combing Hair [ ]  Shaving

[ ]  Doing Laundry [ ]  Ironing [ ]  Cooking [ ]  Vacuuming [ ]  Washing Dishes [ ]  Dusting [ ]  Movie going [ ]  Dining Out [ ]  Shopping

[ ]  Kneeling [ ]  Social events [ ]  Going to Church.

[ ]  Sexual relationships [ ]  Reading [ ]  Watching TV

[ ]  Child care [ ]  Using phone [ ]  Computer work

[ ]  Mowing Lawn [ ]  Gardening [ ]  Washing Car

[ ]  Outside House Maintenance [ ]  Landscaping [ ]  Taking out Trash

[ ]  Aerobic exercising [ ]  Backpacking [ ]  Basketball [ ]  Bowling [ ]  Boxing [ ]  Bicycling [ ]  Basketry [ ]  Baseball [ ]  Fishing

[ ]  Fencing [ ]  Dancing [ ]  Camping

[ ]  Card Playing [ ]  Handball [ ]  Golf

[ ]  Football [ ]  Judo [ ]  Hunting

[ ]  Hockey [ ]  Health Club [ ]  Gymnastics

[ ]  Yoga [ ]  Petitioning [ ]  Karata

[ ]  Ice Skating [ ]  Horseback riding [ ]  Sailing

[ ]  Rafting [ ]  Racquetball [ ]  Photography

[ ]  Jogging [ ]  Swimming [ ]  Snow Skiing

[ ]  Sewing [ ]  Weightlifting [ ]  Water sports

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How do the following positions or motions affect your pain?**

No Change Relieves Increased **If increases**, Duration limited to #?

Sitting [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Walking [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Standing [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Lying Down [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Looking up [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Looking Down [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Lifting [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ weight / repetitions

Bending [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

**Auto Injury Management**

@ Complete Care Health Services

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**Employment History / Change**

Were you employed at the time of the collision?: YES [ ]  NO [ ]

did you loose your job due to this collision?: YES [ ]  NO [ ]

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor / Boss name; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your job Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss time from work due to this collision?: YES [ ]  NO [ ]

If yes:

Day: Date: Amount of time:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has /Have you and or your Boss modified any your work responsibilities due to the effects of this collision? YES [ ]  NO [ ]

if so explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Prior Medical History: (you have been treated for, before/ outside this car crash):**

**Other doctors seen** For Health Conditions (BEFORE or Not from this car crash**),**

[ ]  Orthopedist [ ]  Neurologist [ ]  Psychiatrist [ ] Physiatrist [ ]  Chiropractor

[ ]  Acupuncturist [ ]  General Practitioner [ ]  Physical Therapist [ ]  Massage Therapist

[ ]  Xray / MRI [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If so give:**

Clinic name Practitioner’s Name Phone number Date(s) seen \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

**Personal Medical History & Review of Systems**:

Please indicate with an “X” any medical problems that you currently have or have had in the past.

**Lungs / Pulmonary – breathing disorders OR** □ **NO problems in this area**

□ asthma □ pulmonary embolism □ respiratory arrest

□ COPD □ pneumonia □ sleep apnea

□ emphysema □ tuberculosis □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiac / Heart and peripheral vascular disease OR** □ **NO problems in this area**

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia

□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease

□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis

□ bleeding problems □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurologic Disorders OR** □ **NO problems in this area**

□ stroke or TIA □ Parkinson’s □ cerebral palsy

□ peripheral neuropathy □ MS □ polio

□ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bone & Joint Disorders OR** □ **NO problems in this area**

□ osteoarthritis □ gout □ osteomyelitis

□ rheumatoid arthritis □ lupus □ ankylosing spondylitis

□ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal Disorders OR** □ **NO problems in this area**

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type \_\_\_\_\_\_

□ acid reflux, GERD □ irritable bowel □ liver disease

□ GI bleed □ inflammatory bowel disease

□ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary Disorders OR** □ **NO problems in this area**

□ urinary tract infection □ kidney problems □ dialysis, kidney failure

□ bladder problems □ kidney stones □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Metabolic & Other Disorders OR** □ **NO problems in this area**

□ Diabetes x \_\_\_\_\_\_\_\_ years □ skin disorder \_\_\_\_\_\_\_\_\_\_\_\_\_ □ depression

□ thyroid problems □ psoriasis □ anxiety

□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency

□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancer: any type -- please specify** **OR** □ **NO problems in this area** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: *(please list all medications, food environmental issues that cause allergic reaction)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: *(please list all medications, social drugs and supplements that you currently take)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

**Surgical History:** Please list ALL previous surgery / approximate date on which it was performed:

Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other medical problems NOT included above, Yes □ (Use back of sheet to explain)**

**Family Health History**:

Please indicate with an “X” any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea

□ COPD or Emphysema □ other lung :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ heart attack, myocardial infarction □ congestive heart failure

□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy □ MS or Parkinson’s □ other neuro :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ osteoarthritis □ Lupus □ gout

□ rheumatoid arthritis □ Other bone & joint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type \_\_\_\_\_

□ liver disease □ other GI :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ kidney problems □ dialysis, kidney failure □ diabetes □ psoriasis □ high cholesterol or lipids □ thyroid problems □ sickle cell disease

□ any skin ulcer □ Malignant hyperthermia

Family Cancer: any type -- please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family medical problems NOT included above (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Habits: (regular “Pre”- Automobile crash)**

**Smoking:** \_\_\_ Yes \_\_\_ No If yes, Ave:\_\_\_\_\_\_ Packs per Day, for \_\_\_\_\_ years

**Alcohol:** \_\_\_ Yes \_\_\_ No If yes, Number of drinks per week \_\_\_\_\_\_\_\_

**Caffeine:** \_\_\_ Yes \_\_\_ No If yes, Number of drinks per day \_\_\_\_\_\_\_\_

**Exercise:** \_\_\_ Yes \_\_\_ No If yes, \_\_\_\_\_\_\_\_ time per week, \_\_\_\_\_\_% Aerobic / \_\_\_\_\_% Weights

**Children**: \_\_\_ Yes \_\_\_ No If yes, Ages : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:** Average \_\_\_\_\_ hours per Night

**Hobbies/ Recreational Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\* I ATTEST THAT I, have reviewed pages 1 through 13 of this Auto Collision / Personal Injury Intake form and the information I have provided, is to the best of my recollections, Truthful / Factual / Accurate. \*\*\*\***

**Name Printed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(If for/minor’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

**Office Policies/Fees/Assignment of Benefits**

**Consent to Treatment or Testing with Liability Release:**

You authorize Complete Care Health Services Inc (CCHS), and its authorized subsidiaries and technicians, to administer treatment and/or testing. Furthermore, while the chances of injury are slim, you agree to hold CCHS and its staff without fault for any injuries that may occur during the procedures or advice given to you. Special note to patients with breast augmentation: although rare, there may be risk of implant rupture. Please advise your chiropractic physician before any manipulation/adjustment procedure.

**Verification of Non-Pregnancy:**

You attest to the best of your knowledge that you are not pregnant, nor is pregnancy suspected at this particular time. If you think you might be pregnant, please advise your CCHS physician or CCHS technician.

**Release of Patient Records:**

You authorize CCHS to furnish your insurance carrier, attorney, and/or referring physician with documentation/reports relating to the case history, examination, diagnosis, treatment, and prognosis. This release of records is pursuant to the representative above as only for the accident/illness for which you are being treated for. Furthermore, CCHS has the right to release any and all records required for remuneration purposes. Fees relating to such records are the patient’s responsibility. If requesting records and/or reports, fees for such records/reports must be prepaid.

**Missed Appointment Fees:**

If you cannot make an appointment and need to cancel, we require a **minimum 24-hour** advance notice. Should we not receive such notice, a minimum $55 no show fee, or the equivalent of the service fee you missed, will be assessed to your account. This is a non-reimbursable fee that your insurance WILL not pay and is your sole responsibility.

**Returned Checks/Insufficient Funds:**

Returned checks, insufficient funds, or expired debit/credit cards have a $45 per incident fee.

**Special Arrangements/Agreements:**

Any special arrangements/agreements must be in writing. No verbal agreements.

**Verification of Information/Financial Responsibility:**

Any information asked of me will be accurately given. I understand that providing incorrect information can be dangerous to my health and possibly illegal. I also authorized payment to be made directly to CCHS in the amount due for all service charges for myself and my eligible dependents. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents. Any collection fees, court costs, attorney fees, refund check fees, insufficient funds fees, and interest fees are the responsibility of the person(S), including parent and/or legal guardian, named on the account.

I certify that I have read and understand the above information to the best of my knowledge.

**Name Printed:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(If for a minor, minor’s name:**­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**)**

**Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

**HIPPA Laws:**

This office follows HIPPA law standards described below. We cannot discuss any patients’ care or even acknowledge if they are a patient, including family members, without written permission given first hand by the patient and/or legal guardian themselves.

**HIPPA Notice of Information Practices**

1. Complete Care Health Services (CCHS) may use and disclose protected health information for treatment, payment, and health care operations. Example of these include, but are not limited to, request (e.g. by preschool, life insurance, sports physical, referral to nursing homes, foster care homes, home health agencies, and/or referral to other health providers for treatment), payments (e.g. workers compensation, general insurance companies for claims including coordination of benefits with other insurers and collections agencies), healthcare operations (e.g. internal quality control and assurance).
2. CCHS is permitted or required to use or disclose protected health information without the individual’s written consent or authorization in certain circumstances. Two examples: public health requirements or court orders.
3. CCHs will not make any other use or disclosure of a patient’s protected health information without the individual’s written authorization. Such authorization may be revoked at any time. Revocation must be done in writing.
4. CCHS may, at times, contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient.
5. CCHS will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. CCHS reserves the right to change the terms of its notice as to make any notice provision effective for all protected health information that it maintains.
7. CCHS will provide each patient with a copy of any revisions of its notice of information practice at the time of their next visit or at their last known address. If there is a need to use or disclose any protected health information of the patient, copies may also be obtained at any time from our office.
8. Any person/patient may file a complaint to the practice and to the Secretary of Health and Human Services if they believer their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the above address and or phone number. All complaints will be addressed and the results will be reported to the Corporate Compliance Office/Managing Physician Board of Directors.
9. It is CCHS’s policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. The name, title, and telephone number for the person in the office to contact for further information: Dr. Kevin Luck, President, (303) 985-0646
11. The effective date (cannot be earlier than the date on which the notice is printed or otherwise signed)

**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

**HIPPA Notice of Information Practices (Continued)**

*Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations*

I understand that as a part of my healthcare, CCHS originates and maintains helath records describing my health history, symptoms, examination w/test results, diagnosis, treatment, and any future plans for future care or treatment. I understand that this information serves as:

* A basis for planning care and treatment
* A means for communicating among the many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify that services billed were provided
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures.

I understand that I have the right to review the notice prior to signing consent.

I understand that the practice reserves the right to changer their notice and practices, and prior to implementation, will mail a copy of any such revised notice to the address I have provided.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the practice is not required to agree to the restriction request.

I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reference thereon.

I request the following restrictions to the use or disclosure of my health information:

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Please list any person you wish authorized to access your account:

(No information can be shared with anyone not listed on this form)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(below this line for office use only)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Accepted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Denied

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Title Date