**Celanese Chiropractic Health & Performance**

P: (803) 323-5500

F: (803) 323-5501

1924 Mount Gallant Rd.

Rock Hill, SC 29732

## PATIENT INFORMATION

Full Name _____ Date of Birth _____ Gender M F

Address _____SS# _____-_____-_____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

In order to receive text reminders, please provide your phone carrier ( AT&T, Verizon, Sprint, etc.)_____

Email _____ Referred by _____

Marital Status S M W D Sep. / Spouse Name _____ Date of Birth _____

Are you a student Y N / Full-time Part-time

Your Employer _____ Your Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Employer _____ Spouse's Occupation _____

Insurance Provider _____ Member ID _____

Insurance policy holder's name _____ Date of Birth _____

Current medications _____ Are you or could you be pregnant? ☐ YES ☐NO

Do you exercise? ☐ YES ☐ NO If yes how many times a week? _____

### Family History

| | Mother | Father | Siblings |
|---|---|---|---|
| Back Pain | | | |
| Neck Pain | | | |
| Headaches | | | |
| Pinched Nerve | | | |
| Scoliosis | | | |
| Arthritis | | | |

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the notice of privacy practices of this office. (Once information is disclosed, it may not be protected by law.)

Patient's Signature _____ Date _____

Spouse's or Guardian Signature _____ Date _____

(Authorization expires three years from date above)

# CASE HISTORY

History of Present Injury/ Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaints.

1 _____ How long? _____

2 _____ How long? _____

3 _____ How long? _____

4 _____ How long? _____

What words would best describe your condition(s)? (example: ache, burn)_____

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe) 0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? _____

When is your condition least severe? _____

What makes your condition feel worse?_____

What makes your condition feel better? _____

What activities are difficult because of your condition(s)? _____

Is your condition(s) related to an accident? ☐ YES NO Date of accident _____

Type of accident: Auto Work Related Other _____

Have you seen any other health care provider for your present condition? YES NO Name of provider/facility _____

Are you experiencing or do you have any of the following?

| | | |
|---|---|---|
| A sore that won't heal | Difficulty Swallowing | Persistent cough/hoarseness |
| Any bleeding/discharge | Lump/thickening anywhere | Wart/ mole changes |
| Bladder/bowel problems | Night Pain | None of the above |

**Review of systems**

In addition to the symptom(s) / dysfunction(s) listed above, are you experiencing any of the following?

**Neuromusculoskeletal System**

| | | | |
|---|---|---|---|
| Anxiety | Facial drooping | Memory loss | Sensory changes |
| Atrophy | Headache | Mood swings | Speech problems |
| Concussion | Joint deformity | Muscle weakness | Stiffness |
| Depression | Joint locking | Numbness | Tremors |
| Difficulty Walking | Lack of coordination | Popping noises | Twitches |
| Dizziness | Limited range of motion | Psychiatric disorders | Vision trouble |
| Extremity deformity | Loss of balance | Seizures | **None of the above** |

**Cardiovascular System**

| | | | |
|---|---|---|---|
| Ankle swelling | Chest pain | Jaw pain | Pin stroke |
| Blood clots | Dizziness | Known vascular | Previous stroke |
| Carotid blockage | Fainting | Mitral valve prolapse | Shortness of breath |
| Changes in skin color | Hypertension | Phlebitis | Varicose veins |

**Past History**

List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc.)

1._____ Date _____ 3._____ Date _____

2._____ Date _____ 4._____ Date _____

Have you ever been hospitalized for anything in addition to surgeries? YES NO

If so, when and for what reason? _____

Have you ever been diagnosed as having a particular condition? (Diabetes, heart trouble, cancer)

YES NO _____

Are you currently under a doctor's care for conditions other than the ones you are seeking care for?

YES NO _____

# CELANESE CHIROPRACTIC HEALTH & PERFORMANCE

## AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give consent to release this information to the individuals indicated below. This consent form will not allow Celanese Chiropractic Health & Performance to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Celanese Chiropractic Health & Performance to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

Patient Name:_____

Patient Signature:_____ Date:_____

## AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally it is necessary for the staff of Celanese Chiropractic Health & Performance to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Celanese Chiropractic Health & Performance discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name:_____

Patient Signature:_____ Date:_____

*For Office Use Only: Patient ID*_____

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www.celanesechiropractic.com

# ACCIDENT QUESTIONNAIRE

Patient's Name_____ Date of Injury_____ Today's Date_____
Insurance Comp: _____Claim Number_____
Adjuster Name: _____Adjuster Phone: _____

## DESCRIBE YOUR VEHICLE

1. **Vehicle Type :**
   a. Sports Car
   b. Coupe
   c. Sedan
   d. Sports Utility Vehicle
   e. Station Wagon
   f. Pick-up truck
   g. Bus
   h. Other:_____

   Make:_____

   Year:_____

   Model:_____

   Estimated Speed:_____

2. **Vehicle Size:**
   a. Compact
   b. Mid-Sized
   c. Full-Sized

## DESCRIBE THE ACCIDENT

3. **Date of Accident:**

   _____

4. **Actions of patient's vehicle:**
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. traveling at posted speed limit
   f. traveling faster than the posted speed limit
   g. turning

5. **How was the patient's vehicle hit:**
   a. hit head-on
   b. was hit on the left front
   c. was hit on the right front
   d. was hit on the left rear
   e. was hit on the right rear
   f. was rear-ended
   g. Other:

   _____

6. **Damage to patient's vehicle:**
   a. totaled
   b. heavy
   c. minimal
   d. moderate

7. **Describe the second vehicle:**
   a. compact
   b. full size
   c. mid size
   d. semi trailer
   e. pick-up truck

   Make:_____

   Year:_____

   Model:_____

   _____ Estimated Speed:_____

8. **Damage to the other vehicle?**
   a. total
   b. heavy
   c. minimal
   d. moderate

9. **Weather Conditions**
   a. Clear
   b. Cloudy
   c. Drizzling
   d. Foggy
   e. Rainy
   f. Snowy
   g. Stormy
   h. Sunny

10. **Road Conditions**
    a. Damp
    b. Dry
    c. Dry with icy patches
    d. Iced over
    e. Snowed over
    f. Wet

## DESCRIBE THE MOMENT OF IMPACT

11. **Body position at time of impact:**
    a. leaning forward
    b. slouched down in seat
    c. straight
    d. turned to the left
    e. turned to the right

12. **Direction body was thrown:**
    a. backward then forward
    b. forward then backward
    c. to the left
    d. to the right
    e. about the vehicle
    f. outside the vehicle
    g. under the vehicle

13. **Head position at impact:**
    a. straight
    b. tilted forward
    c. turned to the left
    d. turned to the right

14. **Direction head was thrown:**
    a. backward then forward
    b. forward then backward
    c. side to side

15. **Type of restraint:**
    a. lap belt
    b. shoulder belt
    c. shoulder lap belt

16. **Place patient was seated in the vehicle:**
    a. Driver
    b. front passenger
    c. back passenger driver side
    d. back passenger right side
    e. back passenger middle
    f.
    other_____

17. **Did Airbags deploy:**
    a. yes
    b. no

18. **Did you lose consciousness?**
    a. yes
    b. no

19. **Did your head hit the headrest?**
    a. yes
    b. no

20. **Did Police arrive at the scene?**
    a. yes
    b. no

21. **Was an accident report filled out?**
    a. yes
    b. no

22. **Was your vehicle towed?**
    a. yes
    b. no

23. **Were you seen at a Medical Facility following your accident:**
    a. Yes
    b. No
    **If so name and address of the facility:**

_____

_____

**Patient Signature**

_____

**Guardian's Signature**

_____

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

## ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Celanese Chiropractic Health & Performance to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows: I irrevocably assign to Celanese Chiropractic Health & Performance any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the Chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Celanese Chiropractic Health & Performance, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgements, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Celanese Chiropractic Health & Performance for services rendered.

In the event that I retain one or more attorneys to represent me in this matter who are not located in SOUTH CAROLINA, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I appoint Celanese Chiropractic Health & Performance as my attorney in fact to affix my name as an endorsement upon the reverse of any checks or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Celanese Chiropractic Health & Performance. I authorize Celanese Chiropractic Health & Performance to release to any insurance with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

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

_____ _____
Patient Name (Printed) Patient Signature

_____ _____
Date Witness

## NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Celanese Chiropractic Health & Performance hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. Celanese Chiropractic Health & Performance hereby requests that if its claim is not paid in full from the foregoing proceed, a full disclosure and accounting of proceeds by provided in conformity with N.C.G.S. 44-50.1. Celanese Chiropractic Health & Performance agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Celanese Chiropractic Health & Performance
By:_____

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Dr. Clay Gasparovich

# DOCTOR'S LIEN

I do hereby authorize Celanese Chiropractic Health & Performance and Dr. Clay Gasparovich to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the inquiries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

_____ _____

Date Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above-named.

_____ _____

Dated Attorney's Signature

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