DELMARVA CHIROPRACTIC
AND WELLNESS CENTER

203 Shaw Ave.
Harrington, DE 19952
Phone: 302-682-7975
Fax: 302-566-6046
www.delmarvawellness.com

Patient Name:_____ **DOB:**_____

Todays Date:_____

Motor Vehicle Accident Health History Form

Date of Accident:_____ **Approximate Time of Accident**:_____

Make & model of patients vehicle: _____

Year of patients vehicle:_____

Make & model of other vehicle involved?_____ Year:_____

Any additional vehicles involved? **YES** **NO** If yes, how many?_____

Type(s) of vehicles?_____

Were you the: (Circle one)

Driver **Rear passenger (left side)** **Rear middle passenger**

Front seat passenger **Rear passenger (right side)**

Were you restrained by a seatbelt? **YES** **NO**

Did the airbags deploy? **YES** **NO**

Where was your head facing when the collision occurred?

Straight ahead **Looking left** **Looking down**

Looking right **Looking up**

Was the pavement **(WET)** or **(DRY)** at time of accident?

Did your seat have a headrest? **YES** **NO**

Did you make contact with interior of your vehicle? **YES** **NO**

What body parts made contact (if applicable):_____

Where was contact made (ex: dashboard, steering wheel, etc.)?_____

Did you receive a head injury? **YES** **NO**

Did you lose consciousness? **YES** **NO**

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How many vehicles struck your car/truck? _____

What is the make and model of their vehicle?_____ Year?_____

Where there any additional vehicles involved in the accident? **YES** **NO** How many?_____

Approximately how fast were you going at the time of impact? _____**MPH**

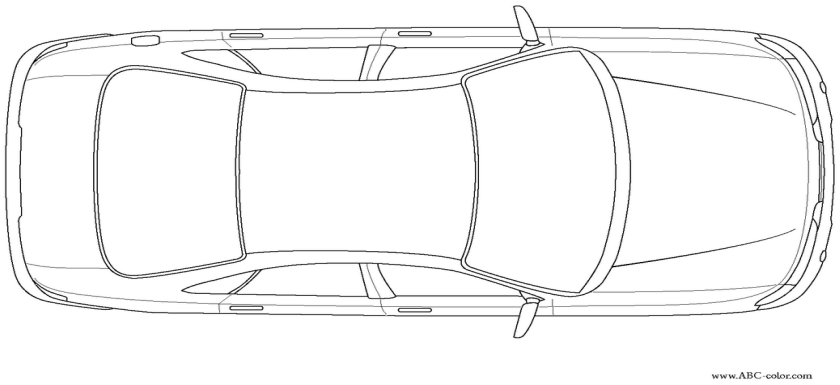
Approximately how fast was the other car going at the time of impact? _____**MPH**

About how far did your vehicle travel after being struck? _____ feet

If your car was standing still at the time of the accident, where were your feet?

Pressed on the brake **Resting on the brake** **Off of the brake**

On the diagram below, please mark the point(s) of impact of your vehicle.



What direction did the impact come from?_____

After the accident, did you strike anything else? **YES** **NO**

If yes, please explain:_____

Was there any damage done to your vehicle?

None **Mild** **Moderate** **Totaled**

Was there any damage done to the other vehicle?

None **Mild** **Moderate** **Totaled**

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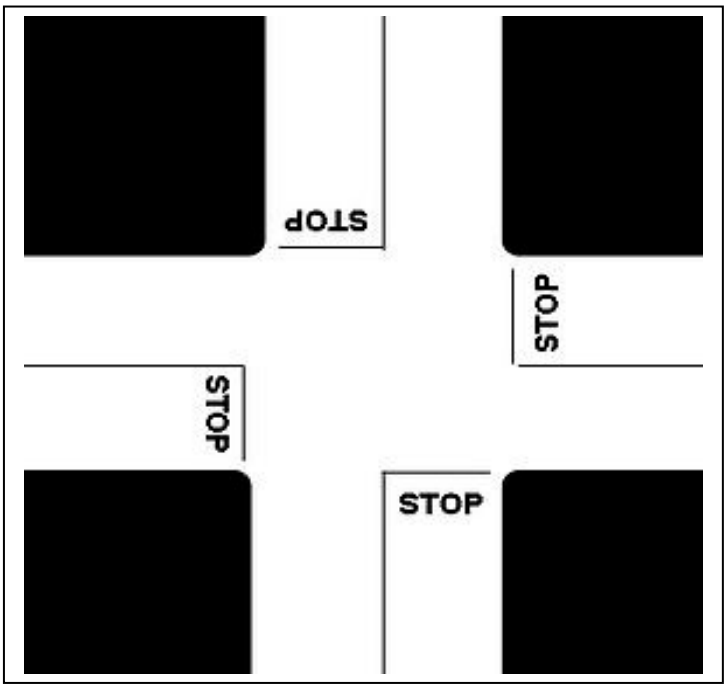
Below, please describe how the accident occurred (in your words). Use the diagram below of an intersection if it's helpful. **Please label your vehicle as #1**



_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Was your vehicle towed? **YES** **NO**

Where the police at the scene? **YES** **NO**

Was an accident report created? **YES** **NO**

Did EMS arrive at the scene? **YES** **NO**

Did you go to the hospital after the accident? **YES** **NO**

Did you travel by: **Your Car** **Ambulance** **Other transportation**

How long after the accident did you arrive at the hospital?_____

How did you leave the hospital? **Someone drove me** **I drove myself**

Were x-rays or any other imaging performed? If yes, please explain:_____

_____

Did you receive treatment or any prescriptions/medications at the hospital? If yes, please explain:_____

_____

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Other than the hospital, have you visited any other health care provider(s) since the accident? If yes, please explain (please provide names and phone numbers):_____

_____

Were you aware of the collision when it occurred? **YES** **NO**

If yes, did you brace or arms or legs? **YES** **NO**

Did you have any immediate pain from the collision? **YES** **NO**

Please describe discomfort/pain (if applicable)?_____

_____

Where was the pain/symptoms felt?_____

_____

Were you ejected from the vehicle? **YES** **NO**

Did you sustain any injuries outside of your vehicle? **YES** **NO**

Did you suffer from any bruises, cuts, or broken bones as a result of the collision?

YES **NO**

Did you suffer from any of the following additional symptoms? (Circle all that apply)

Dizziness	Difficulty Sleeping
Light headedness	Difficulty with Speech
Severe headaches	Feelings of depression/sadness
Vertigo	Feelings of nervousness/anxiety
Blurry vision	Crying for no reason
Confusion	Ringing in ears
Memory loss	Numbness/Tingling
Extreme drowsiness	Muscle weakness
Difficulty with focus/concentration	Nausea/Vomiting
Sensitivity to light	Visual disturbance
Other:_____	

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Have you ever been involved in a motor vehicle accident before? **YES** **NO**

If yes, please answer the five questions below:

1. When and where did the accident(s) occur?
   A. _____
   B. _____
   C. _____

2. Who did you see for care?
   A. _____
   B. _____
   C. _____

3. What type of care did you receive?
   A. _____
   B. _____
   C. _____

4. Did all your symptoms resolve from the above mentioned accidents? **YES** **NO**
   If not, what symptoms persisted? _____
   _____

5. Did any remaining symptoms affect your daily activities in any way? **YES** **NO**
   If yes, please explain: _____
   _____

Patients Name (please print): _____

Patients Signature: _____ Date: _____

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Informed Consent to Chiropractic Adjustments and Care

I consent to the performance of chiropractic adjustments and other chiropractic procedures on me including various modes of physical therapy or diagnostic x-rays by Dr. Jesse Riggin and/or other licensed Doctor of Chiropractic employed at this practice.

I understand that there are some risks to chiropractic treatment including, but not limited to, fractures, discs injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate all possible risks and complications, however I wish to rely on the doctor to act in my best interests based upon the facts known.

I have read, or have had read to me, the above consent. I have had the opportunity to discuss with Dr. Riggin the nature and purpose of chiropractic procedures as well as the associated risks. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Acknowledgment of Receipt of HIPPA Notice of Privacy Practices

I hereby acknowledge that I have received a current copy of Delmarva Chiropractic and Wellness Center's "Notice of Privacy Practices" **(available upon request)**. A representative of DCWC has explained the "Notice of Privacy Practices" to my satisfaction. I am aware that DCWC has included a provision that it reserves the right to change the terms of its notice. I have read the Privacy Notice (Ref. form 2016.7.19) and understand my rights contained in the notice. By way of my signature, I provide DCWC with my authorization and consent to disclose my protected healthcare information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

HIPPA Requests *(You Must Check One)*

- ☐ *I wish to file a* ***"Request for Restriction"*** *of my Protected Health Information.*
- ☐ *I wish to file a* ***"Request for Alternative Communications"*** *of my Protected Health Information.*
- ☐ *I wish to object to the following in the* ***"Notice of Privacy Practices".***
- ☐ ***I agree with the current policy.***

I have read and agree to the "Informed Consent to Chiropractic Adjustments and Care" as well as the "Acknowledgment of Receipt of HIPPA Notice of Privacy Practices". I certify that I am the patient or legal guardian listed below and that the included information is true and accurate to the best of my knowledge.

******If the patient is under the age of 18, a parent must sign this form and be present for the initial appointment.***

*****Parent Name (Printed): _____**

Patient Name: _____

Patient/Guardian Signature: _____

Date:___/____/_____