

# ULERY CHIROPRACTIC



## SPINE, SPORT & REHAB

**Todd Ulery, DC, CCSP**

*Certified Chiropractic Sports Physician*

109 Crossroads Road, Suite 206

Scottdale, PA 15683

724-887-4661

[www.ulerychiropractic.com](http://www.ulerychiropractic.com)

### AUTO ACCIDENT PATIENT INFORMATION & CONDITION

#### PERSONAL INFORMATION

TODAY'S DATE \_\_\_\_\_ ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

NAME \_\_\_\_\_ EMAIL \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ GENDER M / F SOCIAL SECURITY NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ UNEMPLOYED

EMPLOYER \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ARE YOU A STUDENT NO / YES ☐ FULL-TIME ☐ PART-TIME SCHOOL NAME \_\_\_\_\_

SPOUSE NAME \_\_\_\_\_ SPOUSE DATE OF BIRTH \_\_\_\_\_ SPOUSE PHONE \_\_\_\_\_

SPOUSE OCCUPATION \_\_\_\_\_ SPOUSE'S EMPLOYER \_\_\_\_\_

EMERGENCY CONTACT NAME & RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

HOW DID YOU LEARN ABOUT US \_\_\_\_\_

#### PERSONAL INSURANCE INFORMATION

INSURANCE \_\_\_\_\_ POLICY/ID # \_\_\_\_\_ GROUP# \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PHONE \_\_\_\_\_

#### MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

#### AUTO CLAIM INFORMATION

INSURANCE COMPANY \_\_\_\_\_ CLAIM # \_\_\_\_\_

ADDRESS FOR CLAIMS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ADJUSTERS NAME \_\_\_\_\_ PHONE \_\_\_\_\_ EXTENSION \_\_\_\_\_

## BASIC INFORMATION ABOUT THE ACCIDENT

DATE ACCIDENT OCCURRED \_\_\_\_\_ TIME OF DAY ACCIDENT OCCURRED OR STARTED \_\_\_\_\_:\_\_\_\_AM / PM

DESCRIBE HOW THE ACCIDENT TOOK PLACE \_\_\_\_\_

DESCRIBE THE CONDITION OR SYMPTOMS CAUSED BY THE ACCIDENT \_\_\_\_\_

## AUTO ACCIDENT SPECIFIC INFORMATION

WERE YOU THE ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN

AUTOMOBILE YOU WERE IN YEAR \_\_\_\_\_ MAKE \_\_\_\_\_ MODEL \_\_\_\_\_

DAMAGE TO YOUR CAR ☐ FRONT ☐ REAR ☐ PEDESTRIAN ☐ DRIVER SIDE ☐ PASSENGER SIDE ☐ BUMPER ☐ FENDER

DAMAGE AMOUNT ESTIMATE \$ \_\_\_\_\_ ☐ MINOR ☐ MODERATE ☐ MAJOR ☐ TOTALED ☐ UNSURE

OTHER AUTOMOBILE YEAR \_\_\_\_\_ MAKE \_\_\_\_\_ MODEL \_\_\_\_\_

DAMAGE TO OTHER CAR ☐ FRONT ☐ REAR ☐ PEDESTRIAN ☐ DRIVERS SIDE ☐ PASSENGER ☐ BUMPER ☐ FENDER

DAMAGE AMOUNT ESTIMATE TO OTHER CAR ☐ MINOR ☐ MODERATE ☐ MAJOR ☐ TOTALED ☐ UNSURE

WHERE DID THE ACCIDENT HAPPEN STREET NAME(S) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

WAS IT ☐ CONTROLLED INTERSECTION ☐ UNCONTROLLED ☐ NOT INTERSECTION

WAS THERE A TRAFFIC LIGHT ☐ NONE ☐ GREEN ☐ RED ☐ TURN ARROW ☐ STOP SIGN

WERE YOU ☐ SLOWLY MOVING ☐ MOVING ☐ STOPPED

WEATHER CONDITIONS ☐ SUNNY ☐ RAINY ☐ CLOUDY

STREET SURFACE ☐ DRY ☐ WET ☐ SLICK ☐ ICY ☐ PAVEMENT ☐ OTHER \_\_\_\_\_

TYPE OF IMPACT ☐ REAR-ENDED ☐ FRONT ☐ SIDE IMPACT ☐ ROLL OVER

BRAKES ON IMPACT ☐ LOCKED TIGHT ☐ LOOSELY APPLIED ☐ FOOT NOT ON BRAKE

HOW FAR DID YOUR CAR MOVE ☐ DID NOT MOVE ☐ MOVED 1-5 FT ☐ MOVED 6-10 FT ☐ MOVED OVER 10 FT

WHERE WERE YOU SEATED IN THE VEHICLE \_\_\_\_\_ WEARING A SEATBELT ☐ YES ☐ NO

SHOULDER HARNESS: ☐ YES ☐ NO HEADREST: ☐ YES ☐ NO HEADREST POSITION: ☐ UP ☐ DOWN

IS THE VEHICLE EQUIPPED WITH AIRBAGS ☐ YES ☐ NO DID THEY DEPLOY ☐ YES ☐ NO

DID YOU SEE THE IMPACT COMING ☐ YES ☐ NO DID YOU BRACE YOURSELF FOR IMPACT ☐ YES ☐ NO

ON IMPACT, YOUR HEAD WAS LOOKING ☐ AHEAD ☐ BEHIND ☐ UP ☐ DOWN ☐ TO THE RIGHT ☐ TO THE LEFT

ON IMPACT YOU WERE ☐ THROWN FORWARD ☐ THROWN BACKWARD ☐ THROWN SIDEWAY ☐ OTHER

DID YOUR BODY HIT ANYTHING INSIDE THE CAR ☐ YES ☐ NO BODY PART: \_\_\_\_\_

WHAT DID IT HIT \_\_\_\_\_

HEAD TRAUMA ☐ YES ☐ NO LOSS OF CONSCIOUSNESS: ☐ YES ☐ NO IF YES- FOR HOW LONG: \_\_\_\_\_

DO YOU REMEMBER THE ACCIDENT HAPPENING ☐ YES ☐ NO

HOSPITAL ☐ YES ☐ NO NAME OF HOSPITAL \_\_\_\_\_ HOW LONG THERE \_\_\_\_\_

TAKEN BY AMBULANCE ☐ YES ☐ NO

X-RAYS TAKEN ☐ YES ☐ NO X-RAY AREAS ☐ NECK ☐ MID-BACK ☐ LOW-BACK ☐ OTHER \_\_\_\_\_

MEDICATION GIVEN ☐ YES ☐ NO IF YES- RX: \_\_\_\_\_

OTHER INSTRUCTIONS \_\_\_\_\_ FOLLOW UP \_\_\_\_\_

### ADDITIONAL INFORMATION RELATED TO THE CONDITION

DESCRIBE YOUR PAIN ☐ BURNING ☐ SHARP

☐ DULL ☐ ACHE ☐ NUMB/TINGLING

RATE YOUR PAIN

No PAIN--1--2--3--4--5--6--7--8--9--10--SEVERE PAIN

IS THE PAIN ☐ CONSTANT or does it ☐ COME and GO

DOES THE PAIN INTERFERE WITH YOUR

☐ WORK ☐ SLEEP

☐ DAILY ROUTINE ☐ RECREATION

ARE ANY OF THE FOLLOWING PAINFUL TO PERFORM

☐ SITTING ☐ STANDING ☐ WALKING

☐ BENDING ☐ LYING DOWN

HAVE YOU MISSED WORK OR SCHOOL AS A RESULT OF YOUR INJURIES ☐ YES ☐ NO

WHAT CAUSED YOUR PAIN \_\_\_\_\_

WHAT AGGRAVATES YOUR PAIN \_\_\_\_\_

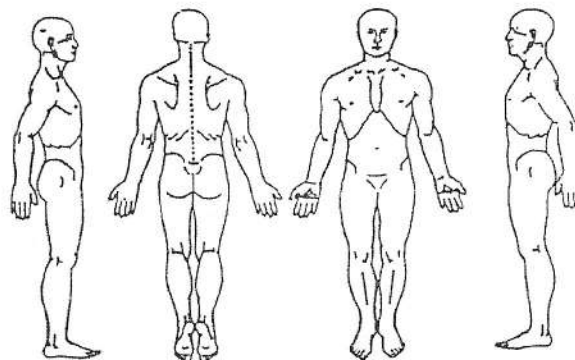
WHAT RELIEVES YOUR PAIN \_\_\_\_\_

HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST ☐ NO ☐ YES -- DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

IF YES PLEASE DESCRIBE \_\_\_\_\_

PLEASE MARK - XXXXXX FOR PAIN

OOOOO FOR NUMBNESS



PLEASE LIST ANY OTHER HEALTHCARE PROVIDERS YOU'VE SEEN FOR THIS CONDITION AND WHEN YOU LAST SAW THEM

NAME	TYPE OF PRACTICE	DATE OF VISIT
_____	_____	_____
_____	_____	_____

## SYMPTOMS

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS

<input type="checkbox"/> HEADACHE	<input type="checkbox"/> CLUMSINESS	<input type="checkbox"/> TINGLING LEGS/FEET	<input type="checkbox"/> NERVOUSNESS	<input type="checkbox"/> NUMBNESS LEGS/FEET
<input type="checkbox"/> LOSS OF MEMORY	<input type="checkbox"/> SLEEPING PROBLEMS	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FAINTING	<input type="checkbox"/> SHARP SHOOTING PAIN
<input type="checkbox"/> HANDS COLD	<input type="checkbox"/> BUZZING IN EARS	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> PAIN ARMS/HANDS	<input type="checkbox"/> NECK PAIN
<input type="checkbox"/> NUMBNESS ARMS/HANDS	<input type="checkbox"/> TENSION	<input type="checkbox"/> CHEST/RIB PAIN	<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> EARS RING
<input type="checkbox"/> COLD SWEATS	<input type="checkbox"/> LOSS OF SMELL	<input type="checkbox"/> LOSS OF STRENGTH LEGS	<input type="checkbox"/> HEAD SEEMS TOO HEAVY	<input type="checkbox"/> BACK PAIN
<input type="checkbox"/> IRRITABILITY	<input type="checkbox"/> BURNING MUSCLE PAIN	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> TINGLING ARMS/HANDS	<input type="checkbox"/> LOSS OF BALANCE
<input type="checkbox"/> LOSS OF STRENGTH ARMS/HANDS	<input type="checkbox"/> LIGHT BOTHERS EYES	<input type="checkbox"/> NECK STIFFNESS	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> FATIGUE
<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> FEET COLD	<input type="checkbox"/> FACE FLUSHED	<input type="checkbox"/> FEVER	<input type="checkbox"/> JAW PAIN

HAVE YOU EXPERIENCED ANY CHANGE TO:

☐ EYES (SIGHT) ☐ EARS (HEARING) ☐ NOSE (SMELL) ☐ MOUTH (TASTE) ☐ BLADDER ☐ BOWELS ☐ SLEEP ☐ EMOTION ☐ APPETITE

PLEASE EXPLAIN \_\_\_\_\_  
\_\_\_\_\_

HAVE YOU BEEN IN OUR OFFICE BEFORE ☐ NO ☐ YES

DO YOU SMOKE ☐ NO ☐ YES # OF PACKS \_\_\_\_\_ HOW OFTEN \_\_\_\_\_

DO YOU DRINK ALCOHOL ☐ NO ☐ YES # OF DRINKS \_\_\_\_\_ HOW OFTEN \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

LIST ANY PREVIOUS ACCIDENTS OR INJURIES (WORK, AUTO OR PERSONAL)

1. _____	DATE _____
2. _____	DATE _____
3. _____	DATE _____

SURGERIES / HOSPITALIZATIONS AND DATES

1. _____	DATE _____
2. _____	DATE _____
3. _____	DATE _____

ALLERGIES \_\_\_\_\_

CURRENT MEDICATIONS AND REASON TAKING \_\_\_\_\_  
\_\_\_\_\_

PLEASE INDICATE IF YOU HAVE EVER HAD OR IF YOU NOW HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> KIDNEY DISEASE      | <input type="checkbox"/> PROSTHESIS           |
| <input type="checkbox"/> ANEMIA            | <input type="checkbox"/> DIABETES            | <input type="checkbox"/> LIVER DISEASE       | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> ANOREXIA          | <input type="checkbox"/> EPILEPSY            | <input type="checkbox"/> MIGRAINE HEADACHES  | <input type="checkbox"/> STROKE               |
| <input type="checkbox"/> ARTHRITIS         | <input type="checkbox"/> FRACTURES _____     | <input type="checkbox"/> MULTIPLE SCLEROSIS  | <input type="checkbox"/> THYROID PROBLEMS     |
| <input type="checkbox"/> ASTHMA            | <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> OSTEOPOROSIS        | <input type="checkbox"/> TUMORS/GROWTH        |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> HEPATITIS           | <input type="checkbox"/> PARKINSON'S DISEASE | <input type="checkbox"/> OTHER _____          |
| <input type="checkbox"/> BREAST LUMP       | <input type="checkbox"/> HERPES              | <input type="checkbox"/> PINCHED NERVE       | _____   |
| <input type="checkbox"/> BULIMIA           | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> POLIO               | _____   |
| <input type="checkbox"/> CANCER _____      | <input type="checkbox"/> HIGH CHOLESTEROL    | <input type="checkbox"/> PROSTATE PROBLEMS   |   |

ARE YOU PREGNANT OR ANY POSSIBILITY YOU MAY BE PREGNANT ☐ YES ☐ NO ☐ UNCERTAIN

I HAVE READ, UNDERSTOOD, AND AGREE TO THE FOREGOING. THE INFORMATION WHICH I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# ULERY CHIROPRACTIC



## SPINE, SPORT & REHAB

**Todd Ulery, DC, CCSP**

*Certified Chiropractic Sports Physician*

109 Crossroads Road, Suite 206

Scottdale, PA 15683

724-887-4661

[www.ulerychiropractic.com](http://www.ulerychiropractic.com)

### PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, \_\_\_\_\_, HEREBY AUTHORIZE ULERY CHIROPRACTIC TO USE AND DISCLOSE MY HEALTH INFORMATION IN THE MANNER DESCRIBED BELOW.

1. RELEASE OF EXAMINATION AND TEST RESULTS TO PHYSICIANS, HOSPITALS, AND HEALTH CARE AGENCIES INVOLVED IN MY CARE.
2. I AUTHORIZE ULERY CHIROPRACTIC TO PROVIDE ME COPIES OF TEST RESULTS UPON MY REQUEST AND WILL ASSUME RESPONSIBILITY FOR SAFEGUARDING THIS HEALTHCARE INFORMATION FROM IMPROPER DISCLOSURE
3. I AUTHORIZE ULERY CHIROPRACTIC TO DISCLOSE MY HEALTH CARE INFORMATION AND/OR BILLING INFORMATION TO THE FOLLOWING PERSON WHO IS INVOLVED WITH MY CARE:  
\_\_\_\_\_  
\_\_\_\_\_

4. I AUTHORIZE ULERY CHIROPRACTIC TO RECEIVE HEALTH CARE INFORMATION FROM ANY PHYSICIAN OR HEALTH CARE AGENCY DIRECTLY INVOLVED IN MY CARE. THIS APPLIES TO VERBAL, WRITTEN AND ELECTRONIC SUBMISSIONS.
5. THIS AUTHORIZATION IS IN EFFECT UNTIL I REVOKE IT AND I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING ULERY CHIROPRACTIC IN WRITING. I AM AWARE THAT MY REVOCATION IS NOT EFFECTIVE TO THE EXTENT OF THE PERSONS THAT I HAVE AUTHORIZED TO USE/OR DISCLOSE MY HEALTH INFORMATION HAVE ACTED IN RELIANCE UPON THIS AUTHORIZATION.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

IF THIS AUTHORIZATION IS SIGNED BY A PATIENT'S PERSONAL REPRESENTATIVE ON BEHALF OF THIS PATIENT, PLEASE COMPLETE THE FOLLOWING:

\_\_\_\_\_  
NAME OF PERSONAL REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\*NOTE THAT THIS FORM MAY BE USED TO DOCUMENT THE FOLLOWING TYPES OF PERSONAL REPRESENTATIVE RELATIONSHIPS: 1) MAKING APPOINTMENTS FOR HEALTH CARE SERVICES 2) DISCUSSION WITH HEALTH CARE PROVIDERS ABOUT ROUTINE TESTS AND TREATMENT (DO NOT REQUIRE INFORMED CONSENT) 3) ACCESS TO MEDICAL RECORDS.

\*NOTE THAT THIS FORM ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE PATIENT HAS RECEIVED OR BEEN MADE AWARE OF ULERY CHIROPRACTIC'S NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION.

# ULERY CHIROPRACTIC



## SPINE, SPORT & REHAB

**Todd Ulery, DC, CCSP**

*Certified Chiropractic Sports Physician*

109 Crossroads Road, Suite 206

Scottdale, PA 15683

724-887-4661

[www.ulerychiropractic.com](http://www.ulerychiropractic.com)

### RELEASE OF RESPONSIBILITY

#### ALL INSURANCE RECIPIENTS

IN THE EVENT OF NON-PAYMENT BY AN INSURANCE CARRIER (HEALTH, AUTO or WORKERS COMP), I TAKE FULL RESPONSIBILITY FOR PAYMENT OF ALL TREATMENT RENDERED BY ULERY CHIROPRACTIC.

BY MY SIGNATURE, I ACKNOWLEDGE THAT IF MY INSURANCE CARRIER DENIES PAYMENT I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT AND THAT I AM ALSO RESPONSIBLE FOR ANY CHARGES OR BALANCES NOT COVERED BY MY INSURANCE CARRIER.

#### MEDICARE RECIPIENTS

IN ACCORDANCE WITH THE MEDICARE ACT, SECTION 1842 (1), THIS NOTICE IS TO ADVISE YOU THAT MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE REASONABLE AND NECESSARY UNDER SECTION 1852 (1) OF THE MEDICARE ACT. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH NORMALLY COVERED, IS NOT REASONABLE AND NECESSARY UNDER MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE.

BY MY SIGNATURE, NOTIFICATION BY MY DOCTOR THAT HE BELIEVES IN MY CASE MEDICARE IS LIKELY TO DENY PAYMENT FOR THE SERVICES RENDERED FOR THE REASON STATED ABOVE. IF MEDICARE DENIES PAYMENT I AGREE TO BE PERSONALLY RESPONSIBLE FOR PAYMENT AND THAT I AM ALSO RESPONSIBLE FOR ANY CHARGES OR BALANCES NOT COVERED BY MY INSURANCE CARRIER.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
IN OUR OFFICE WE SPECIALIZE IN TREATING THE NEURO-MUSCULOSKELETAL SYSTEM. WE UTILIZE X-RAYS TO HELP INSURE AN ACCURATE DIAGNOSIS AND PROPER TREATMENT PLAN. MANUAL ADJUSTMENTS, ELECTRICAL MUSCLE STIMULATION, ULTRASOUND, CRYOTHERAPY (ICE), MOIST HEAT, INTERSEGMENTAL TRACTION, REHABILITATIVE EXERCISES, AND DIOWAVE LASER ARE UTILIZED IN THIS OFFICE AS PART OF YOUR TOTAL HEALTH CARE.

IF DR. ULERY FEELS THAT YOUR CONDITION CANNOT BE TREATED CHIROPRACTICALLY, A PROPER REFERRAL WILL BE MADE IMMEDIATELY. THEREFORE, WE MUST BE INFORMED OF ANY NEW OR EXISTING PROBLEMS THAT YOU MAY BE HAVING.

I AM FULLY AWARE OF DR. ULERY'S RECOMMENDATIONS FOR CARE AND I AM AUTHORIZING TREATMENT THEREOF.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE