Spine & Extremity Rehab Center

1221 Lafayette Street, Santa Clara, CA 95050

Patient Information

First Name: _____ **Middle name:** _____ **Last Name:** _____

Date of birth: _____

Address:_____

_____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer/Occupation: _____

Name of Primary Doctor **if any**: _____ City: _____ Date of Last Visit: _____

Name:_____ **Date Of Injury:** _____

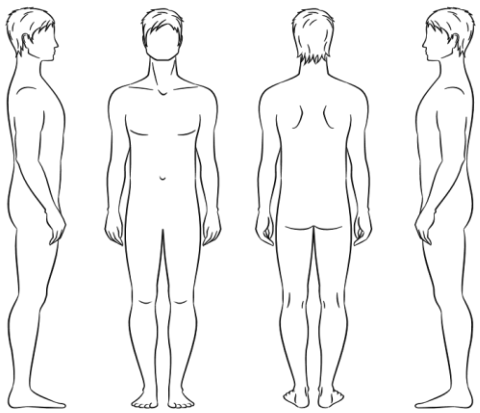
Height:_____ **Weight:**_____

Primary Area of Concern/Pain
Indicate (x) on drawing to the right where you have pain/symptoms

Describe the pain/condition (tingling, numbness, sharp, stiffness, etc.)
_____
_____
_____

Rate your pain/condition (10 being worst)
1 2 3 4 5 6 7 8 9 10

Mark with (X)



Please indicate if you have (had) ANY of the following conditions:

□ DVT □ Recent sudden dizziness □ Fever lasting more than a day
□ Cardiovascular □ Recent Severe abdominal pain □ Any Allergies
□ Stroke □ **Pacemaker** □ Severe Headaches □ **Cancer** □ Arthritis
□ Surgery □ **None of the above**

☐Other serious medical conditions: _____

Note:_____

_____

_____

_____

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Injury History Form

General Information

Patient's name: _____ Today's date: _____

Date of injury: _____

Any prior treatment or injuries to affected areas: ☐Yes, (explain below) ☐No

_____

_____

Injury History General

what city did the accident occur in? _____

You were: ☐Driver ☐Front seat passenger ☐Rear seat passenger ☐Motorcycle operator ☐Motorcycle passenger ☐Other

Vehicle driven by: _____

Time of day: ☐Daylight ☐Dawn ☐ Dusk ☐Dark

Was the seat back adjustment altered by the crash? ☐Yes ☐No

Was the seat broken? ☐Yes ☐No Seat belt: ☐Wearing ☐ Not wearing ☐None ☐Don't know

Did the airbag deploy? ☐Yes ☐No If yes, were you struck? ☐Yes ☐No

Body position at time of impact: ☐Neutral ☐ Forward lean ☐Other_____

Head position at time of impact: ☐Forward ☐Left ☐Right ☐Up ☐Down

Hands: ☐One on wheel ☐Two on wheel ☐N/A Brake applied? ☐Yes ☐No

Aware of the impending crash? ☐Yes ☐No Did you brace for the crash? Yes No

During the Crash

Did your face hit anything during the accident? ☐Yes, _____ ☐No

Did your neck hit anything during the accident? ☐Yes, _____ ☐No

Did you slide out of your seatbelt during the accident? ☐Yes ☐No

What was damaged in/on your vehicle? (check all that apply)

☐Windshield ☐Steering wheel ☐Dashboard ☐Seat frame ☐Side window ☐Rear window ☐Rear bumper ☐Front bumper
☐Trunk ☐Front left door ☐Front right door ☐Back left door ☐Back right door ☐Knee bolster ☐Completely totaled

Did you lose consciousness? ☐Yes ☐No If yes, for how long? _____

If there were lacerations (cuts), where were they? ☐Head ☐Neck ☐Abdomen ☐Upper/Mid back ☐Lower back
☐Pelvis Chest/Rib cage ☐Shoulders (R, L) ☐Arms (R, L) ☐Elbows (R, L) ☐Forearms (R, L) ☐Wrists (R, L) ☐Hands (R, L)
☐Buttocks (R, L) ☐Hips (R, L) ☐Thighs (R, L) ☐Knees (R, L) ☐Legs (R, L) ☐Ankles (R, L) ☐Feet (R, L) ☐Other _____

Did you receive emergency care at the accident site? ☐Yes ☐No If yes, what type of care? ☐Bandages ☐Splints
☐Brace ☐Neck collar Other _____

Were the police on-scene? ☐Yes ☐No If yes, was a report made? ☐Yes ☐No

After the Crash/Injury

Symptoms you have experienced: ☐Headache ☐Dizziness ☐Nausea ☐Neck pain ☐Back pain ☐Blurred vision ☐Double vision ☐Reduced vision ☐Chest pain ☐Palpitations ☐Impaired hearing ☐Constipation ☐Diarrhea ☐Vomiting ☐Anxiety ☐Tension ☐Frequent urination ☐Depression ☐Mood swings ☐Painful urination ☐Nervousness ☐Poor memory ☐Convulsions ☐Fatigue ☐Restlessness ☐Loss of balance ☐Insomnia ☐Weakness ☐Light sensitivity ☐Weight gain ☐Weight loss ☐Reduced Appetite ☐Ringing in ears ☐Difficulty breathing ☐Confusion/disorientation ☐Inability to hold urine ☐Numbness/Tingling If yes, where? _____
☐Extremity pain If yes, where? _____
When did symptoms first appear?
☐Immediately ☐After _____hour(s)after the accident, please clarify which symptom _____
Where did you go after the crash? ☐Home ☐Work ☐Hospital ☐Private doctor Doctor's name _____
Are you restricted in any of the following areas as a result of the accident? ☐Daily living ☐Occupational/Work ☐Recreational activities ☐Other _____

Emergency department Radiographs: ☐Yes ☐No ☐X-rays ☐MRIs ☐CT ☐Special Imaging
Body parts imaged: _____ Results: _____
Cervical Collar? ☐Yes ☐No Ice? ☐Yes ☐No Medications (list): _____
Other: _____ Were you admitted? ☐Yes ☐No
Follow-up instructions: _____ ☐None

Treatment history since the accident/injury

1. Dr.: _____Specialty: _____ Date first seen: _____
Treatment given: _____ Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A Did treatment help? ☐Yes ☐No
Notes:_____
_____

2. Dr.: _____ Specialty: _____ Date first seen: _____
Treatment given: _____ Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A Did treatment help? ☐Yes ☐No
Notes:_____
_____

3. Dr.: _____Specialty: _____ Date first seen: _____
Treatment given: _____ Currently treating? ☐Yes ☐No
Special tests done: _____

DOCTOR'S LIEN

I, the undersigned, understand that all past, present, and future bills incurred at the Doctor/Clinic noted below are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness without financial hardship, I give you a lien on any settlement, claim, judgment, verdict, or result of said accident/injury/illness.

This lien is secured with any real and personal property I own at the present time as well as the future.

I also understand that if the settlement does not cover my bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim, or judgment which I may eventually recover.

Mehdi Panahi, DC, QME, IIE.
1221 Lafayette Street
Santa Clara, CA 95050
Phone: (408) 622-0878 Fax: (800) 918-1901

****Furthermore, I understand that this lien **should be signed by my designated attorney** as well as myself. In the event that my attorney refuses to sign this lien, my account balance will be declared due and payable immediately. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

Patient Name (Please print): _____

Date of accident/injury/illness for which this lien pertains: _____

Patient(s) or Legal Guardian(s) signatures:

_____ _____
Signature **Date**

* * * * *

ATTORNEYS ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of this Doctor's Lien and agree to honor it.

Name: _____

Address: _____

_____ _____
Attorney's Signature **Date:**

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in the improvement of symptoms, fractures, disc injuries, strokes, dislocations, sprains, and skin burns due to using modalities. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with the hopes of avoiding more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise of a cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name: _____ **Date**: _____

Signature (If Under 18, Guardian/Parent signature): _____

Doctor(s) of Chiropractic: Mehdi Panahi, DC, QME, IIE / Rabeah Emampour, DC, QME.

Signature of Doctor of Chiropractic: _____ **Date**: _____

PATIENT HIPPA AWARENESS

With my permission, this office (Dr. Mehdi Panahi, Dr. Rabeah Emampour, or any of their associates) may use and disclose protected health information (PHI) about me to carry out treatment, payment, communication with other healthcare facilities/physicians, and healthcare operations (PHO).

This office reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to the Office.

With my permission, the office may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out PHO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With my permission, the office may mail to my home or other designated location any items that assist the practice in carrying out PHO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

I have the right to request that this office restrict how it uses or discloses my PHI to carry out PHO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing this office to use and disclose my PHI for PHO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Print Name (Patient or Legal Guardian)

_____ _____

Signature (Patient or Legal Guardian) **Date**