



**Springbok Wellness and Rehab, LLC**  
**Springbok Chiropractic, LLC**

1400 N Gilbert Rd, Suite M  
Gilbert, AZ, 85234  
P (480) 558-0474 F (480) 558-0478

**NEW PATIENT PACKET**

**FOR PERSONAL INJURY &**

**WORKMAN'S COMPENSATION PATIENTS**

**Patient Intake Sheet**

*Please note: All first visit charges are payable when services are rendered.*

How did you hear about our Wellness Center? \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

SSN \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Male  Female  Single  Married  Divorced  # of children \_\_\_\_\_

Current Employer \_\_\_\_\_ Work ph: \_\_\_\_\_

Have you had Chiropractic, Physical Therapy, Occupational Therapy or Speech Therapy this year?  Yes  No

Which? \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

I authorize Springbok Wellness & Rehab and/or Springbok Chiropractic to release medical information to above named person in the event of an Emergency:  Yes  No

**Insurance Information**

Type of Insurance:  General Insurance  Worker Comp  Auto/Personal Injury  Medicare

Primary Ins Name: \_\_\_\_\_ Ins ID# \_\_\_\_\_

Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Secondary Ins Name: \_\_\_\_\_ Ins ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Insurance Policy Holder**

Relation to Patient:  Self  Spouse  Parent  Other Sex:  M  F

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Please provide your insurance card and a photo ID to the receptionist for documentation purposes. All co-pays/fees for visits are due upon finishing initial paperwork and before seeing the treating clinician. Thank you.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*NOTE : We will do a courtesy insurance verification to see how much your insurance will help you with your care.*

# HEALTH HISTORY FORM

## HISTORY

Is this a work related or auto accident related injury? \_\_\_\_\_

What treatment have you already received for this condition?

\_\_\_ Medications \_\_\_ Surgery \_\_\_ Physical Therapy \_\_\_ Chiropractic care \_\_\_ None

Exercise frequency: \_\_\_\_\_ Type of exercise: \_\_\_\_\_

Do you or have you ever smoked? Yes/No If so, how often? \_\_\_\_\_

Are you pregnant? Yes/No

Do you have a Pacemaker, Defibrillator or Neurostimulator? Yes/No

Allergies? \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

Previous surgeries/Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you fallen within the last 6 months? Yes/No

### DO YOU HAVE ANY OR HAVE HAD A HISTORY OF THE FOLLOWING?

AIDS/HIV

ANEMIA

ANGINA

ARTERIOSCLEROSIS

ASTHMA

BLOOD CLOTS

CANCER

CHEMICAL DEPENDENCY

CIRCULATION PROBLEMS

DEPRESSION

DIABETES

EPILEPSY

EYE INFECTION

FIBROMYALGIA

HEART DISEASE

HEMOPHILIA

HIGH BLOOD PRESSURE

LOW BLOOD PRESSURE

LIVER PROBLEMS

JOINT/BONE INFECTION

MULTIPLE SCLEROSIS

OSTEOARTHRITIS

OSTEOPOROSIS

RHEUMATOID ARTHRITIS

STROKE

TUBERCULOSIS

URINARY INFECTION

# CURRENT COMPLAINT

What is your major complaint? Please list all. \_\_\_\_\_

When did it start? \_\_\_\_\_ Cause of pain/injury? \_\_\_\_\_

Previous treatment for current pain? \_\_\_\_\_

What positions or activities relieves your pain? \_\_\_\_\_

What time of day are symptoms worse? \_\_\_ Morning \_\_\_ Mid-Day \_\_\_ Evening \_\_\_ Bed time

Current duration of pain: \_\_\_ Intermittent \_\_\_ Constant \_\_\_ Certain motions

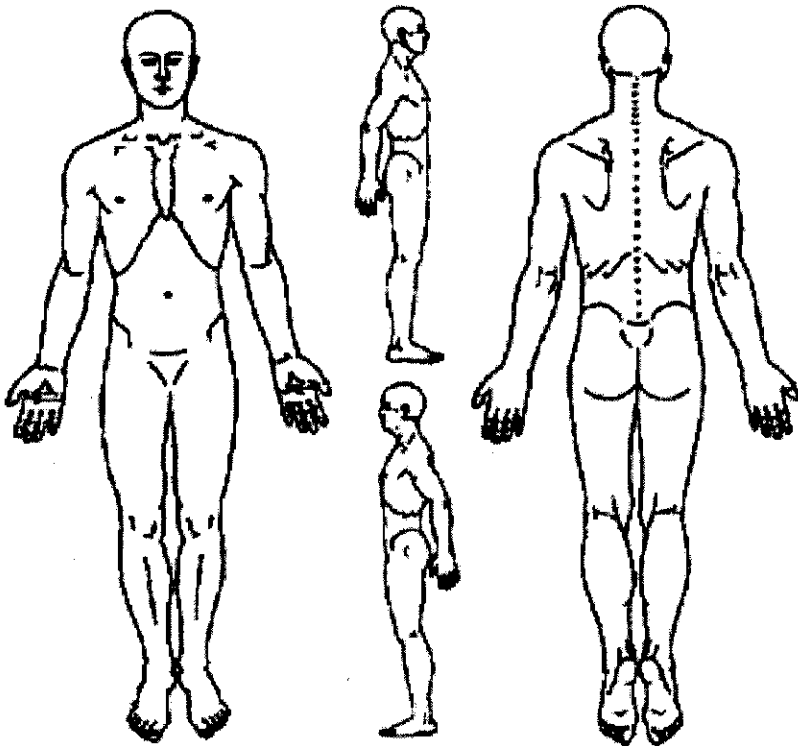
Current level of pain: 0-1-2-3-4-5-6-7-8-9-10 (Zero is no pain; 10 is THE worst pain ever!!)

How would you describe your pain? Dull Aching Throbbing Stabbing Pinching Shooting Burning

Is your pain getting better or worse? \_\_\_\_\_ Have you had this injury before? Yes/No

On the diagram below, please show **where** you are currently experiencing your present complaints using the following letters:

**A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



DO YOU HAVE PAIN AND/OR DIFFICULTY PERFORMING ANY OF THE FOLLOWING ACTIVITIES? (CHECK ALL THAT APPLY)

- PERSONAL CARE \_\_\_\_\_
- LIFTING \_\_\_\_\_
- WORK \_\_\_\_\_
- DRIVING \_\_\_\_\_
- SLEEPING \_\_\_\_\_
- WALKING \_\_\_\_\_
- SITTING \_\_\_\_\_
- STANDING \_\_\_\_\_
- BENDING FORWARD \_\_\_\_\_

Patient signature: \_\_\_\_\_

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

ROS: All systems reviewed and WNL except as noted in history of present illness and above: \_\_\_\_\_ Dr. Initial

**AUTHORIZATION TO RELEASE X-RAYS & INFORMATION**

**(Please print name and sign on signature line. Leave all other spaces blank. Do not date.)**

I, \_\_\_\_\_, Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Request the following information:

X rays     MRI     History     Records     Reports     Diagnosis

Concerning my  Illness     Accident     Injury     Other

To be released to the Doctors at Springbok Chiropractic and/or Springbok Wellness and Rehab,  
1400 N. Gilbert Rd. Ste. M, Gilbert, AZ, 85234    Ph: (480) 558-0474    Fax: (480) 558-0478.

I understand I have the right to receive a copy of this authorization upon request.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I am the:  Patient     Parent     Guardian

**PLEASE READ CAREFULLY**

**Health Care Privacy Notice** We are required by law to abide by the terms of the Health Care Privacy Consent and we are committed to maintaining the privacy of your protected health information (PHI). We may change and/or modify the terms of this Consent at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. A copy of the HIPAA document is available at the front desk for you upon request. Please submit record requests in writing and allow up to 10 days for record retrieval especially if archived. Records are stored in archive for 7 years; must submit name of patient at time of treatment.

**Consent to Treat** I understand that Springbok Chiropractic LLC and/or Springbok Wellness and Rehab LLC, its providers & staff are accepting my case based on health history, examination, and diagnostic test findings & believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, examination or providers care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of physical therapy and/or chiropractic there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains and/or other injuries or side effects that cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. To have maximum therapeutic benefit and healing you must follow the plan of care your provider establishes. Therefore, I give my full consent to the doctor/provider to render evaluation and treatment on me, or the minor for whom I am legally responsible.

**Statement of Disclosure** I understand all referrals are made in good faith and per necessity to improve patient outcomes. Under A.R.S. (Arizona Revised Statutes) 32-2051 (C), we are required by law to inform you in writing that your referring physician/chiropractic physician may derive either direct or indirect compensation related to your physical therapy.

**Appointment and Valuable Policy** Office hours allow our patients convenience to schedule appointments. If you must miss an appointment please notify us 24 hours in advance. If you miss multiple appointments without notifying us you will be charged a \$25 cancellation fee. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file. Patients are encouraged to leave valuables at home. This Facility shall not be liable for the loss of or damage to any personal property.

**Assignment of benefits/financial responsibility** 1. We will verify benefits as a courtesy for you. Springbok Wellness and Rehab and/or Springbok Chiropractic does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits. 2. I authorize my insurance carrier to release information regarding my coverage to Springbok Wellness and Rehab and/or Springbok Chiropractic. I authorize agents of any hospital, treatment center or previous physicians to furnish Springbok Wellness and Rehab and/or Springbok Chiropractic copies of any records of my medical history, services, or treatment. I authorize the release of any medical information and/or reports related to my treatment to any physician or insurance carrier as needed. 3. My right to payment for all health products, therapy services, supplies, and durable medical equipment including major medical benefits are hereby assigned to Springbok Wellness and Rehab and/or Springbok Chiropractic. This assignment covers any and all benefits as payment of claims for services. If my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, or my representative, I will endorse such payments to Springbok Wellness and Rehab and/or Springbok Chiropractic. I guarantee payment of all charges for treatment provided to the patient below to Springbok Wellness and Rehab and/or Springbok Chiropractic. I understand I am financially responsible for all charges including but not limited to all copayments, deductibles and expenses not covered or paid by my insurance. I understand the unpaid balance is due in full upon discharge. If legal action is taken against this account I agree to pay for all legal fees associated with this action. If the industrial or auto insurance exhausts or refuses to pay, I authorize Springbok Wellness and Rehab and/or Springbok Chiropractic to bill my health insurance. I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

BY SIGNING BELOW, I AM WITNESSING THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND POLICIES. THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Signature: \_\_\_\_\_

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

### Office Policy

Please note that if your 2018 deductible has not been met, you will be responsible for a visit cost of \$75.00 per visit until your deductible has been met. We will be balancing the account accordingly and informing you of any difference on the account. If the balance due is more than \$75.00 collected, you will be responsible for the difference. Please make sure your insurance has been verified for the New Year.

Thank you.

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Patient Signature

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Date

### Cancellation Policy

24-hour notice is REQUIRED for all cancellations or a \$25.00 fee will be charged for the appointment time held. This policy applies to all patients including Medicare, Workerman's Comp and Personal Injuries. These fees are not covered by insurance companies and will be your responsibility.

Thank you.

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Patient Signature

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Date

**Personal Injury History Form Continued**

**Please fill out Insurance Information thoroughly**

Please make [X] as many of the following statements that apply to your case:

- I have Medical Payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
- I have private health insurance benefits either directly or through my spouse or parents.
- I have retained an attorney
- I have not retained an attorney
- I have the adverse or third party information available (Insurance company of the other driver)

**At Fault Insurance Information (3rd Party):**

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

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

Adjuster's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Your Auto Insurance Information: PLEASE PROVIDE A COPY OF THE DECLARATION PAGE**

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

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

Adjuster's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Attorney Information:**

Firm Name: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Your Health Insurance Information: (Please provide a copy of your insurance card)**

Primary Ins Name: \_\_\_\_\_ Ins ID# \_\_\_\_\_

Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Secondary Ins Name: \_\_\_\_\_ Ins ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_



**Personal Injury History Form**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time of Accident: \_\_\_\_: \_\_\_\_ AM PM

Town and State accident occurred in: \_\_\_\_\_

Weather conditions at the time of accident:  clear  raining  foggy  other

Were you the:  driver  front passenger  rear passenger  pedestrian

Were you wearing a seatbelt?  yes  no Braced for impact?  yes  no

What direction was the impact from?  front  rear  right side  left side

Were there multiple cars involved?  yes  no If yes, how many? \_\_\_\_\_

Were tickets issued?  yes  no If yes, to whom? \_\_\_\_\_

Did you go to the hospital right away?  yes  no Later?  yes  no

If so, which hospital? \_\_\_\_\_

Were you x-rayed?  yes  no What treatment did you receive?  medication  other \_\_\_\_\_

Have you seen other doctors as a result of this accident?  yes  no

If yes, please list: \_\_\_\_\_

Have you missed work as a result of this accident?  yes  no If yes, how many days? \_\_\_\_\_

Have you had any previous permanent injuries as a result of prior accidents, injuries, or illness?  yes  no

If yes, please describe when and what: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Part of the body injured:**

- Abdomen
- Back
- Chest
- Face
- Fingers
- Head
- Mouth
- Nose
- Scalp
- Teeth

- Ankle
- Arm
- Ear
- Elbow
- Eye
- Foot
- Hand
- Knee
- Leg
- Wrist

- Right
- Right
- Right
- Right
- Right
- Right
- Right
- Right
- Right
- Right

- Left
- Left
- Left
- Left
- Left
- Left
- Left
- Left
- Left
- Left

Other (specify) \_\_\_\_\_

**Personal Injury History Form Continued**

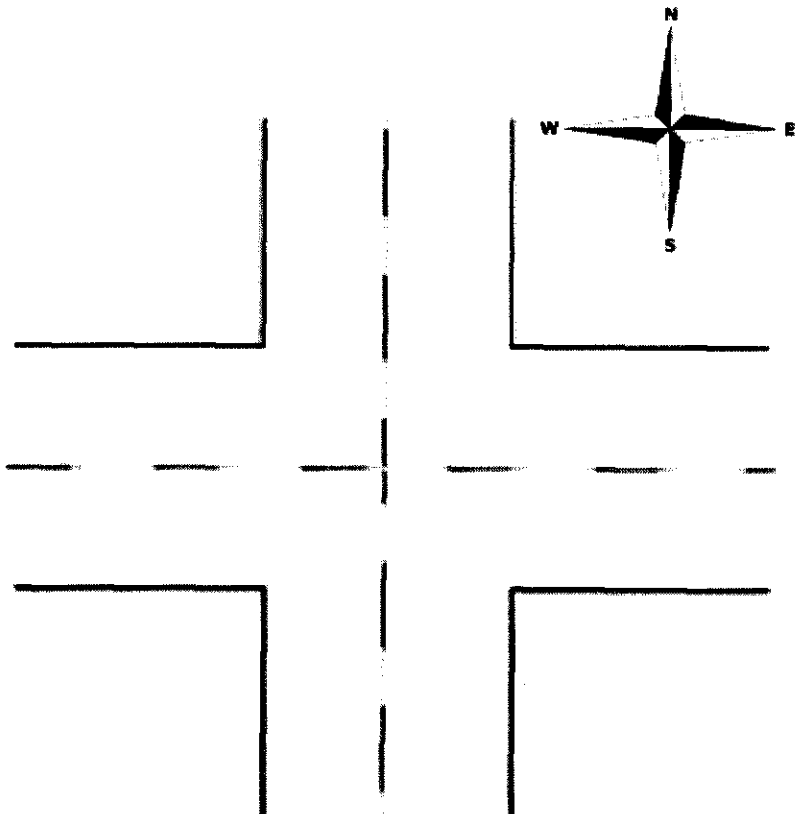
In your own words, briefly describe the accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Did your body strike the inside of your vehicle?  yes  no If yes, what part of your body? \_\_\_\_\_  
 Hit what part of the vehicle? \_\_\_\_\_

Using the diagram below please indicate the following:

- Your car and what direction it was driving
- Other cars involved in the accident and their direction of travel
- Building, posts, road signs, trees, benches, and all other items near the site of the accident

Street(s) \_\_\_\_\_  
 Street(s) \_\_\_\_\_  
 Patient headed (N S E W)  
 Patient speed \_\_\_\_\_ MPH  
 Patient Car Type \_\_\_\_\_  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**What causes you difficulty?**

Standing  Sitting  Lying Down  Other \_\_\_\_\_

<b>Walking</b>	<b>Riding(in auto)</b>	<b>Bending</b>	<b>Twist/Turn</b>	<b>Lifting</b>	<b>Rise to Walk</b>
<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal
<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate
<input type="checkbox"/> Extended	<input type="checkbox"/> Extended	<input type="checkbox"/> Extended	<input type="checkbox"/> Extended	<input type="checkbox"/> Extended	<input type="checkbox"/> Extended

**Does the pain radiate into your...**

<b>Shoulder(s)</b>	<b>Arm(s)</b>	<b>Hip(s)</b>	<b>Leg(s)</b>	<b>Is worse:</b>	<b>Interferes with:</b>
<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> In the AM	<input type="checkbox"/> Work
<input type="checkbox"/> Right	<input type="checkbox"/> Right	<input type="checkbox"/> Right	<input type="checkbox"/> Right	<input type="checkbox"/> In the PM	<input type="checkbox"/> Sleep
<input type="checkbox"/> Both	<input type="checkbox"/> Both	<input type="checkbox"/> Both	<input type="checkbox"/> Both	<input type="checkbox"/> After Activity	<input type="checkbox"/> Other: _____