KAPSNER CHIROPRACTIC CENTERS

Patient Personal Injury & Financial Information

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home # _____ Cell # _____
Driver's License # _____
Social Security # _____
E-mail Address _____
By providing my email, I am allowing the clinic to send me appointment reminders and clinic info.
Employer _____
Employer Address _____
Occupation _____
Work # _____
Spouse Name _____ Phone # of Spouse _____
Name of Nearest Relative or Friend _____ Relationship _____
Relative/Friend's Phone # _____

Financial Information

Personal Injury Protection (Your Policy): This is insurance that is not required by the state of Texas, but most owners carry on their policy. It may be used to cover medical expenses, or to cover a percentage of lost wages. Call your insurance agent to report your accident and request that she/he send you a PIP application. Fill out the application and bring it to the insurance department of Kapsner Chiropractic Centers.

Company Name _____ Adjuster _____
Address _____ Phone # _____
Name of Insured _____ Date of Birth _____
Policy # _____ Claim # _____

Party at Fault Insurance Information:

Company Name _____ Adjuster _____
Address _____ Phone # _____
Name of Insured _____ Date of Birth _____
Policy # _____ Claim # _____

General Health Insurance:

Company Name _____
Name of Insured _____ Date of Birth _____
Policy # _____ Group # _____

Signature _____ **Date** _____

KAPSNER CHIROPRACTIC CENTERS

Accident/Injury Questionnaire

Name _____ **Date** _____

Check any of the following that you have experienced since, and/or as a direct result of this accident or injury. Please add comments accordingly.

___ Headaches
___ Dizziness
___ Anxiety
___ Depression
___ Visual Disturbance
___ Trouble Sleeping
___ TMJ (jaw) Pain or Discomfort
___ Numbness or Tingling
___ Loss of Consciousness
___ Loss of Memory
___ Contusions (black/blue)

Have you had difficulty with any of the following:

___ Housework
___ Lawn or Garden Activities
___ Exercise Routine
___ Standing
___ Walking
___ Hobbies
___ Sports
___ Sitting

Due to this injury/accident, have you undergone any of the following:

___ Medications
___ Injections
___ Surgery
___ Ambulance
___ Hospital/Emergency Room
___ Supports/Casts/Collars/Braces
___ Medical Doctor Treatment or Evaluation - Doctor's Name _____ ___ Off Work - Please List Dates _____

At the time of this accident/injury:

___ Were you wearing a seatbelt?
___ Were you braced, prepared, and or anticipating the accident?
___ Did you strike your head or face?
___ Were the road conditions icy or wet?
___ Did your seat, seatback, or seatbelt break or get damaged?
___ Did your airbag deploy?

Describe your body position at the time of the accident:

_____

_____

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ROUND ROCK: 2000 S. IH 35 • Suite H1 • Round Rock • TX • 78681 • 512-733-1700 • Fax 512-733-1713
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BASTROP TEXAS: 1106 College Street • Ste. A • Bastrop • TX • 78062 • 512-985-5486 • Fax 512-985-5477

Kapsner Chiropractic Centers

Personal Injury History Form

Patient's Name: _____
Today's Date: _____
Date of Injury: _____
Type of Work: ☐ Office/Clerical ☐ Light Labor ☐ Mod Labor ☐ Heavy Labor

Injury History: General
Was the crash on the job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front-passenger ☐ Rear passenger
Vehicle driven by: _____
Vehicle you occupied (year, make, model): _____
Time of Day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other: _____
Headrest: ☐ None ☐ Up ☐ Down
If adjustable, was the position altered by crash? ☐ Yes ☐ No
Was the seat back adjustment altered by crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap Belt: ☐ Wearing ☐ Not Wearing ☐ Don't Know
Shoulder Belt: ☐ None ☐ Wearing ☐ Not Wearing
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body Position: ☐ Good ☐ Forward lean ☐ Other: _____
Head Position: ☐ Forward ☐ Left ☐ Right ☐ Up ☐ Down
Hands: ☐ One on wheel ☐ Two on Wheel ☐ N/A
Brakes Applied? ☐ Yes ☐ No

Crash Description: _____

During the Crash:
Were you aware of the impending crash? ☐ Yes ☐ No
Did you strike any parts of the vehicle? ☐ Yes ☐ No
If yes, describe: _____
Did vehicle strike any objects after crash? ☐ Yes ☐ No
If yes, describe: _____
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long? _____
Estimated damage to the vehicle you occupied ☐ None ☐ Minimal ☐ Moderate ☐ Major
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Police on-scene? ☐ Yes ☐ No Report made? ☐ Yes ☐ No
Were there other passengers in your vehicle? ☐ Yes ☐ No

After the Crash:
Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion
☐ Neck Pain
☐ Numbness/tingling: where _____
☐ Extremity Pain If so, where? _____
☐ Back Pain
When did symptoms appear? ☐ Immediately ☐ hours afterwards ☐ other _____
Where did you go after crash? ☐ Hospital ☐ Home ☐ Work
Mode of transportation getting there: _____
Pvt. Doctor: _____

Emergency Department:
Hospital Name: _____
Radiographs (X-rays, MRI, etc) taken? ☐ Yes ☐ No
Body parts imaged: _____
Results: _____
Treatment issued: ☐ Cervical Collar ☐ Ice ☐ Other: _____
Medications: _____
Follow-up Instructions: ☐ None ☐ Other: _____

Treatment History

1. Dr: _____
Specialty: _____ Date first seen: _____
Treatment type: _____
Treatment Frequency: _____
Treatment Duration: _____
Currently treating? ☐ Yes ☐ No
Referred to: _____
Did the treatment help? ☐ Yes ☐ No
Notes:

I understand and agree that health insurance and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I also authorize my auto insurance or the at fault person's auto insurance company to pay Kapsner Chiropractic Centers directly from any settlement payment.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature Date

KAPSNER CHIROPRACTIC CENTERS

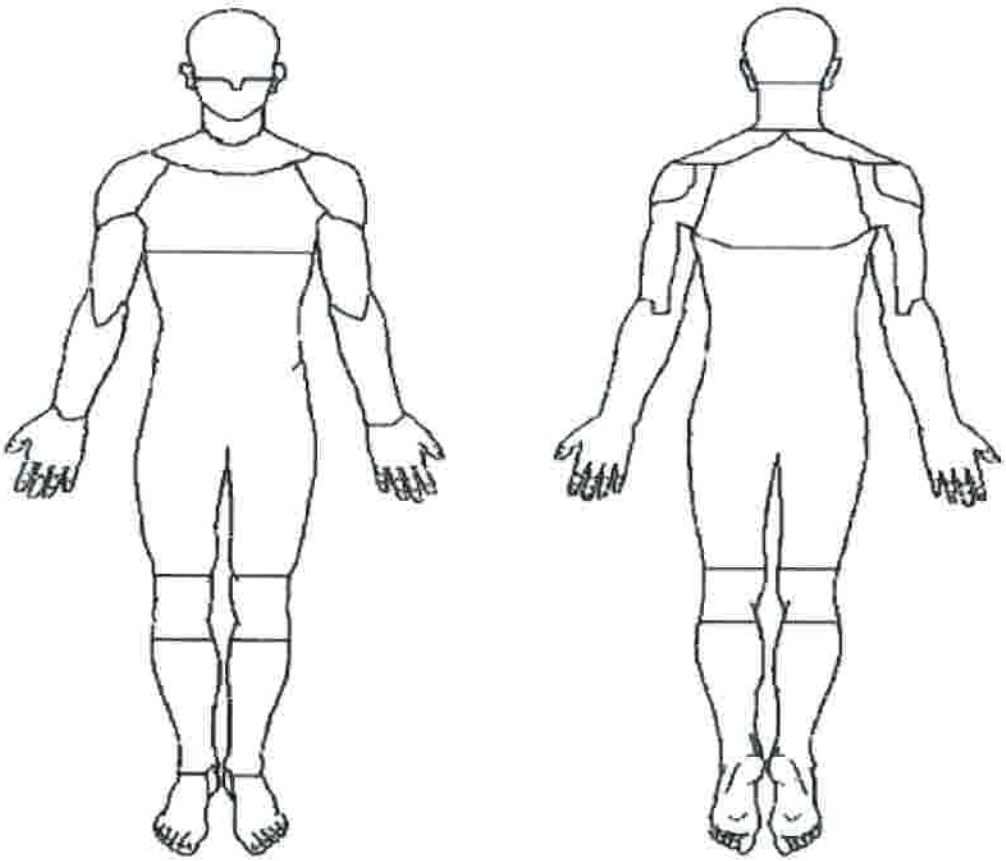
Name _____ Date _____

Nombre Fecha

PAIN DRAWING
DIBUJO DE DOLOR

MARK WHERE YOU HAVE PAIN OR ALTERED SENSATION
MARQUE DONDE SIENTA DOLOR O SENSACION ALTERADA

Pain	Tingling	Burning	Numbness	Stiffness
Dolor	Hormigueo	Ardor	Adormecimiento	Tiesedad



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KAPSNER
CHIROPRACTIC

WWW.KAPSNER.COM

Dr. Michael A. Kapsner, D.C.
Dr. Michael J. Snow, D.C.
Dr. James R. Schiffer, D.C.
Dr. Christopher Curry, D.C.
Dr. Jay A. Heath, D.C.
Dr. Dylan J. Payne, D.C.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic 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.

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 other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks in treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 interest.

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 form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient or patient's representative, if necessary (e.g., if patient is a minor or is physically or mentally incapacitated):

Print Patient's Name	Patient's Signature	Date

Print name of patient's representative	Signature and relationship of patient's representative

******* To be completed by staff *******

Name and address of clinic (Please check one):

_____3005 S. Lamar, Ste D-112 Austin, TX 78704
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_____8440 Burnet Rd., Ste 118 Austin, TX 78757
_____2000 S. IH 35 Ste H1 Round Rock, TX 78681
_____401 E. Whitestone Blvd. C-104 Cedar Park TX 78613
____1106 College Street, Ste A Bastrop, TX 78602

Name of Doctor treating this patient

_____Michael Kapsner, D.C.
_____Jay A. Heath, D.C.
_____Michael Snow, D.C.
_____James Schiffer, D.C.
_____Christopher Curry, D.C.
_____Dylan J.Payne, D.C.