SPINE AND WELLNESS CINCINNATI
ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. **THANK YOU**.

Name____________________________ Sex______ Marital Status______ DOB____________ Home Phone ______________________

Address _________________________________ City______________ State________ Zip_________ Cell #______________________

Email ____ Height _____' ______" Weight __________ lbs

Occupation _______________________________ Who referred you to our office?____

SSN __________________ Business Phone_______________ Company Name ____________________ Location ________________

Spouse________________ Spouse SSN ________________ Spouse Employer____________________ Location _________________

Please explain in detail how your accident happened ____
____
____
____

What were the time and date of present injury? ____

Where did you feel pain immediately after the accident? ____

List the extent of injuries as you know them:____
____
____

Did you require post accident hospitalization? ☐ Yes ☐ No

Check the symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach Upset	☐ Sensitivity to Light	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Fainting	☐ Pins and Needles in Legs	☐ Loss of Balance	☐ Back Pain
☐ Flushed	☐ Numbness in Fingers	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Smell	☐ Fever
☐ Irritability	☐ Shortness of Breath	☐ Loss of Taste	☐ Chest Pain
☐ Cold Sweats	☐ Sleeping Problems	☐ ____________________	☐ __________________

Symptoms other than above:____
____

Where were you taken after the accident? ____

Hospitalized? ☐ Yes ☐ No If yes, admitted?__________________________ How Long?_____________________________
Name of Hospital ____
Name of Doctors ____
What treatment was given? ____

Was there any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? ________________________________ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.
What was the diagnosis? ____
What treatment was given? ____
How often did you see the doctor? ____
How long did you see the doctor? ____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No
If so, what were the complaints? ____

Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

SPINE AND WELLNESS CINCINNATI

Patient Name ____ Date ______________________

PATIENT INFORMED CONSENT

Before you receive care as a patient of Laser Pain Center, it is important that you read this Consent and understand the nature of treatment. Laser Pain Center utilizes a multidisciplinary approach to health and wellness. Treatment usually involves a blend of laser therapy, acupuncture, herbal medicine, and manual medicine. To understand the risk associated with care, you need to understand these unique modalities.

Laser Therapy is a non-surgical application of laser light. Unlike most other forms of therapy, laser therapy is classified "actinotherapy" as it results in a chemical/metabolic change of the involved tissues. Thus, laser therapy can relieve pain, decrease inflammation, accelerate tissue healing (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of medical treatment, there are associate risks as well as benefits. Laser exposure to the eyes during the procedure may result in damage of the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms. To prevent adverse reactions to laser therapy, all patients must adhere to the guidelines for care supplied separately.

"Acupuncture" means a form of health care performed by the insertion and removal of specialized needles, with or without the use of supplemental techniques, to specific areas of the human body. *See* Ohio Statute 4762.

Manual medicine (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

"Chiropractic physicians" examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Ohio Statute 4734.01.

The undersigned Patient understands and acknowledges that there are risks associated with the application of laser chiropractic medicine, chiropractic care, acupuncture, therapy including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, pneumothorax, spinal injury, stroke, vision disturbances and others. The most common side effect following any treatment is an ache or stiffness at the site of the treatment.

I, hereby give authorization for **consent of treatment** to **Laser Pain Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with treatment at Laser Pain Center and application of therapeutic modalities such as Laser, heat, ice, ultrasound, traction, muscle stimulation, acupuncture, herbal medicine, chiropractic and others treatments by **Laser Pain Center**. **All my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X **Date**