CHIROPRACTIC WORKS
PERSONAL INJURY QUESTIONNAIRE

5105 E Sahara Ave Suite 144 Las Vegas, NV 89142 P:(702) 457-9000 F:(702) 457-2020

NAME: _____ DATE: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

HOME PHONE #: _____ CELL #: _____

BIRTH DATE: _____ SEX: M ☐ F ☐ SOC. SEC. #: _____

EMPLOYER'S NAME: _____ PHONE #: _____

ATTORNEY: _____ PHONE#: _____

NATURE OF ACCIDENT:

DATE OF INJURY: _____ TIME: _____ A.M. / P.M.

WERE YOU:
- ☐ DRIVER
- ☐ FRONT PASSENGER
- ☐ REAR PASSENGER
- ☐ PEDESTRIAN

WHERE WAS THE IMPACT?
- ☐ REAR
- ☐ FRONT
- ☐ LEFT SIDE
- ☐ RIGHT SIDE

NUMBER OF PEOPLE IN YOUR VEHICLE: _____

WERE YOU WEARING A SEATBELT? ☐ YES ☐ NO

DID YOUR AIRBAGS DEPLOY? ☐ YES ☐ NO

WERE POLICE NOTIFIED? ☐ YES ☐ NO

PLEASE DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: _____

_____

_____

_____

_____

_____

WHERE WERE YOU TAKEN AFTER THE ACCIDENT? _____

DAYS MISSED FROM WORK SINCE THE ACCIDENT _____

DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

PLEASE LIST ANY PRIOR SURGERIES: _____

_____

_____

HAS ANOTHER DOCTOR TREATED YOU SINCE THE ACCIDENT? ☐ YES ☐ NO

IF YES, WHEN AND WHERE? _____

HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO

IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ HEADACHE	☐ LOWER BACK PAIN	☐ FATIGUE
☐ NECK PAIN	☐ LEG PAIN	☐ EARS RINGING
☐ NECK STIFFNESS	☐ KNEE PAIN ☐ ARM PAIN ☐ SHOULDER PAIN	☐ LOSS OF BALANCE
☐ SLEEPING PROBLEMS	☐ CHEST PAIN	☐ LOSS OF SMELL OR TASTE
☐ UPPER BACK PAIN	☐ TINGLING	☐ UPSET STOMACH
☐ MIDDLE BACK PAIN	☐ NUMBNESS	

SYMPTOMS OTHER THAN ABOVE: _____

_____

HAVE YOU EVER BEEN INVOLVED IN A PRIOR ACCIDENT; AUTO, WORK, OR SLIP AND FALL?

☐ YES ☐ NO

IF SO, WHEN? _____

_____ _____

Signature of patient or legal guardian (if a minor) **Date**

_____

Printed name of legal guardian (if a minor)

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate Chiropractic Works as a representative of any agent or entity, or any insurance company or other organizational entity or person

CHIROPRACTIC WORKS

INFORMED CONSENT FORM

Patient Name: _____

Dear Chiropractic Works patient: Please read this entire document and discuss with the doctor any questions or concerns prior to signing it. It is important that you understand the information contained in this document.

The Nature of the Chiropractic Adjustment:
One of the primary treatments used by a Doctor of Chiropractic is the spinal adjustment or spinal manipulative therapy. We will use this type of procedure with you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" much like one experiences from "popping" knuckles. You may feel a sense of movement.

Analysis, Examination and Treatment:
As part of the analysis, examination and treatment of your condition you are consenting to the following procedures:
Spinal Adjustment/Manipulative Therapy
Range of motion testing
Muscle strength testing
Radiographic Study/Xray
Physical Evaluation and Palpation
Orthopedic examination
Vital Signs
Neurological Examination
Postural Analysis
Intersegmental or static traction and Hydrotherapy
Therapeutic exercises and neuromuscular reeducation
Electrical Stimulation of muscle and/or joint

The material risks inherent in chiropractic adjustment:
As with any healthcare procedure, there are certain complications which may arise with adjustment/manipulation and therapy. These complications include but are not limited to: fracture, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of adjustment/manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. This is similar to soreness associated with working out and the "Lactic Acid" response. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us of said condition.

The probability of risks occurring:
Fractures are rare occurrences and generally the result of an underlying weakness of the bone which will be checked for during your history, examination and on x-ray. Stroke has been the

subject of tremendous disagreement. The most current research of the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote.

The availability and nature of other treatment options:
Other treatment options for your condition may include: self administered over the counter analgesics and rest, medical care and prescription drug such as an anti-inflammatory, muscle relaxants and narcotic pain medication, hospitalization, surgery, and pain injections.

The risks and dangers of conditions remaining untreated:
Remaining untreated may allow the formation of joint adhesions and reduced mobility which may lead to a pain reaction and further reduced mobility. Over time this process may complicate treatment making it more difficult and less effective the longer care is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read or have had read to me the above explanation of the chiropractic adjustment/manipulation and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent for treatment.

To be completed by the patient:	*To be completed by the patient's guardian:*
Print name	Print name of patient (if a Minor)
Signature of patient	Print name of patient's guardian
Date signed	Signature of patient's guardian
	Date signed

To be completed by doctor or staff:

Witness to the patient's signature _____ Date _____

John-Paul Curletto, DC Chiropractic Works 5105 E Sahara Ave Suite 144 Las Vegas, NV 89142
Phone (702) 457-9000 Fax (702) 457-2020

Chiropractic Works

RELEASE OF MEDICAL INFORMATION

5105 E Sahara Ave Suite 144, Las Vegas, NV 89142
Phone: 702.457-9000 | Fax: 702.457-2020

Patient name _____ Date of birth _____
Nombre del paciente *Fecha de nacimiento*

I authorize release of the above named patient's Healthcare Information to:
Autorizo la revelación de la información sobre atención médica del paciente arriba nombrado para:

Chiropractic Works
5105 E Sahara Ave Suite 144, Las Vegas, Nevada 89142
Phone (702) 457-9000 Fax (702) 457-2020

Check ONLY Required Records:

O Medication List O MRI studies O Provider Notes
O Laboratory Results O X-Rays
O Other _____

O Healthcare records covering the period of _____(date) to _____(date)
Expedientes de atención médica que cubre el período de (fecha) a (fecha)

Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

I O DO O DO NOT **authorize release of confidential information concerning:**
Yo autorizo que se compartan los expedientes listados arriba aunque estos expedientes contengan información acerca de (ponga iniciales si aplica):

O Acquired Immunodeficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV) infection
Síndrome de inmunodeficiencie adquirida (SIDA) / Infección por el virus de la inmunodeficiencia humana (VIH)

O Behavioral health / mental health / psychiatric testing, diagnosis, history and/or treatment
Salud conductual I salud mental l pruebas psiquiátricas, diagnóstico, historia o tratamiento

O Alcohol or drug testing, diagnosis, history, and/or treatment
Pruebas de consumo de alcohol o drogas, diagnóstico, historia o tratemienta

O Social Services
Servicios sociales

Reason For Request: (Please check one) *Motivo de la petición: (Marque uno)*

O Medical Care O Insurance O Personal O Attorney O Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Chiropractic Works. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____ IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN 120 DAYS.

Patient or Authorized Guardian Signature _____
(Firma del paciente o del tutor autorizado)

Date *(Fecha)* _____ Witness *(Testigo)* _____

Chiropractic Works
NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a "Notice of Privacy Practice" statement. The following is a generic "Notice of Privacy Practice" statement designed to provide you with an idea of what you should expect to be receiving from your health care provider.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Chiropractic Works is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practice with respect to your protected health information.

Disclosure of Your Health Care Information

TREATMENT
We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or healthcare operations.

PAYMENT
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

WORKERS' COMPENSATION
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to; preventing or controlling disease, injury or disability, reporting child/elderly abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS
We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS
We may disclose your health information to coroners or medical examiners.

ORGAN DONATION
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES
We may disclose your health information for military, national security, prisoner and government benefits purposes.

MARKETING
We may contact you for marketing purposes or fundraising purposes.

CHANGE OF OWNERSHIP
In the event Chiropractic Works is sold or merged with another organization, your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS:
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Chiropractic Works is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than usual method of communication or delivery, upon your request. You have the right to inspect a copy of your health information. You have the right to request that Chiropractic Works amend your protected health information. Please be advised, however, that Chiropractic Works is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Chiropractic Works. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES
Chiropractic Works reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such an amendment is made, Chiropractic Works is required by law to comply with this Notice. Chiropractic Works is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact Chiropractic Works directly.

COMPLAINTS
Complaints about your Privacy rights, or how Chiropractic Works has handled your health information should be directed to Chiropractic Works's Privacy Officer by calling this office at 702-457-9000. If Chiropractic Works's Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

This notice is effective as of 08/08/2012. I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Chiropractic Works with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (PRINT)

_____ _____
Patient's Signature Date

NOTICE OF DOCTOR'S IRREVOCABLE LIEN

PATIENT NAME _____ DATE OF ACCIDENT _____

I do hereby authorize Dr. Curletto of Chiropractic Works to furnish you, my attorney or insurance company, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I do hereby authorize and direct you, my attorney or insurance company, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give an irrevocable lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney or insurance company, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. And I hereby direct that any and all sums to be paid pursuant to this lien will take priority to any and all payments which I may receive as a result of the subject case and direct my attorney or insurance company to render payment to Dr. Curletto prior to payment to myself.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I also direct the appropriate insurance carrier to make available separate check payable to Chiropractic Works should Dr. Curletto or an authorized party make such a request.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to do cooperate in protecting the doctor's interest the doctor will now await payment but may declare the entire balance due and payable. In addition, if the attorney discontinues representation for any reason, or if this irrevocable lien is not returned to the Doctor signed by Client's attorney, Client has executed and grants the Doctor an irrevocable assignment of proceeds.

DATE _____ PATIENTS SIGNATURE _____

SIGNATURE OF PARENT/LEGAL GUARDIAN _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this irrevocable lien is litigated that the prevailing party will be awarded attorney fees and costs.

DATE _____ ATTORNEY'S SIGNATURE _____

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