MOTOR VEHICLE INTAKE FORM

Vibrant Life Acupuncture
15962 SW Boones Ferry Rd, Ste. 202
Lake Oswego, OR 97035
503-515-7702

Patient Name: _____ DOB:_____

Address:_____City:_____State:_____Zip:_____
Contact Tel. No.:_____ Email: _____
Emergency Contact: _____ Telephone: _____ Relationship:_____
List allergies (foods/medications/irritants):_____

Please list any prescribed medications you are currently taking:
Medication Name: Dosage: For What? How Long:
_____
_____
_____
_____

Please list all supplements, vitamins and over-the-counter drugs you are currently taking:
_____
_____

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____
Do you have any of the following? (please circle any that you have)
Hepatitis Cancer Diabetes Heart Disease High blood pressure Pacemaker Blood-thinner medication HIV Seizures

Insurance Information
Please Complete Prior to Appointment

Patient's Auto Insurance Company:_____

Patient's Auto Policy #:_____

Insurance Agent: _____Phone:_____

Medical Adjuster: _____ Phone:_____

Claim #:_____

Claims Billing Address:

_____

Phone:_____

Claim Fax #:_____

Have you retained an attorney: □ Yes □ No

Name:_____
Phone:_____

Auto Accident Information

Date and time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying?

_____

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest?

☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the other vehicle(s) involved?

_____

Name of the location/ street on which you were traveling?

_____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you: ☐ aware ☐ surprised by the impact?

If accident vehicle made impact with another vehicle:

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

AFTER INJURY:

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor:

_____

Describe any treatment you received:

_____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw pain	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/ shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/fingers	☐ Lower back pain
☐ Blurred vision	☐ Tension	☐ Back stiffness	☐ Buzzing in ear
☐ Neck pain	☐ Chest pain	☐ Leg pain	☐ Ears ringing
☐ Neck stiff	☐ Shortness of breath	☐ Numb feet/ toes	☐ Stomach upset

☐ Other (please describe):

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

RECOVERY

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Lifting
☐ Bending	☐ Typing	☐ Stooping

☐ Other: _____

What positions can you work in with minimum physical effort and for how long?

_____

_____

_____

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

Consent To Treatment

Proper evaluation of your current condition includes the appropriate history and physical examination. By signing below you attest that the information above is true and correct and also, you give permission for the acupuncturist to conduct necessary evaluation and treatment.

Printed Patient Name:_____
Patient Signature:_____ Date: _____

If the patient is a minor:
Printed name of Parent/Guardian: _____
Signature of Parent/Guardian: _____ Date: _____

Cancelation Policy

When you schedule your appointment, this time is reserved specifically for you to receive undivided attention and care with your practitioner. In the event that you must cancel your scheduled appointment, please give the courtesy of as much notice as you possibly can. Due to the nature of this practice and the limitation of available appointment slots, a charge will be incurred if you are unable to **give at least 24 hours notice of cancellation for your reserved time.**

It is understandable that an unforeseeable instance may make it impossible for you to keep your appointment, as a courtesy Vibrant Life Acupuncture has the following fee schedule:
Missed appointments are charged $55.

In preventing this fee charge, **please call the office immediately** to cancel your appointment and I will reschedule you an appointment for the same week so you don't miss your treatment.

LATE POLICY

If you are going to be late, please call the office and let me know and I will wait until the time we agree upon. If you do not give notice, I will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the **missed appointment fee of $55.**

Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

PATIENT AGREEMENT

By signing below I am certifying that I have read and understood Stacy Spence, L.Ac., MSOM's Notice of Privacy Practices document and will comply with its provisions.

_____

Signature of Patient or Authorized Representative

_____

Patient Name Printed

_____

Date