INNOVATIVE INJURY SOLUTIONS NEW PATIENT INTAKE

New Patient Demographics

Today's Date: _____

Your Name:_____Gender: □ Male □ Female

Date of Birth:_____Age: _____

Phone Number Cell/Home:_____Email Address:_____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other:_____

Street Address:_____

City/State/Zip:_____

Physical Address Same as Mailing? □ Yes □ No

If not, please list mailing address:_____

Emergency Contact Name: _____Phone Number:_____

Preferred Pharmacy

Pharmacy Name:_____Phone Number: _____

Street Address:_____City:_____State:_____Zip: _____

Clinical Information

Height:_____Weight: _____

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = Numbness; "S" = stabbing; "B" =burning
"P" = pins and needles; "A" = aching

Pain Description

_____ What number on the pain scale (0-10) best describes your pain **right now**?

Where is your worst area of pain located?

_____

_____

Does this pain radiate? If so, where?

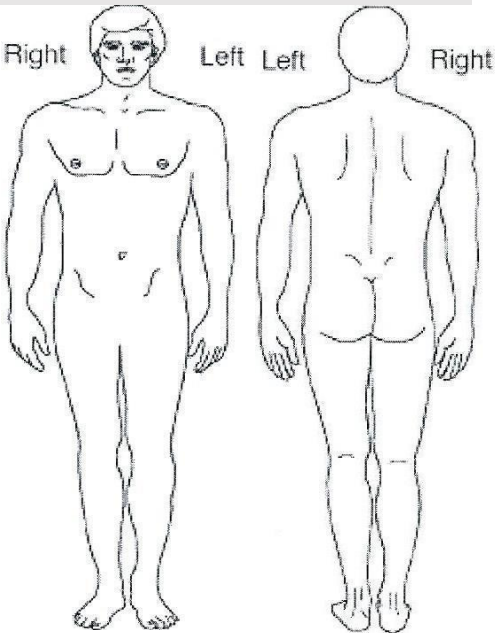
_____

_____

Please list any additional areas of pain

_____

_____



INNOVATIVE INJURY SOLUTIONS

Patient Name:_____ Today's Date:_____

Date of accident: _____ Where did the accident occur? City_____ State: _____

Where were you sitting?	**Where was your car hit?**	**On which side was your car hit?**
☐ Driver seat ☐ Front Right	☐ Rear-end ☐ Front-end	☐ Left side ☐ Right-side
☐ Rear Left ☐ Rear Right	☐ T-Bone ☐ Other_____	☐ Other_____

Did you lose consciousness? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Did the Airbag deploy? ☐ Yes ☐ No

Have any X-rays/CT scans/MRIs been taken? ☐ Yes ☐ No

Did you receive a ticket? ☐ Yes ☐ No

Did the other party receive a ticket? ☐ Yes ☐ No

Has liability been accepted by the at fault insurance: Yes No Pending

At fault driver name: _____At fault address: _____

At fault party Insurance Co: _____ Policy #: _____

At fault vehicle make/model: _____

What symptoms are you currently experiencing now from the accident? (Start with the worst complaint:

_____

What was your treatment **on the day** of theaccident/injury?_____

What has been your treatment **since** the accident/injury?_____

Which doctors **have you seen** regarding thisaccident/injury?_____

Did any of your present symptoms exist before the accident? ☐ Yes ☐ No (If Yes, please describe)

_____

Have you received other treatments for these same areas in the past? ☐ Yes ☐ No
If so, what were the treatments?_____

Do you think that these symptoms are directly related to the accident? ☐ Yes ☐ No

INNOVATIVE INJURY SOLUTIONS NEW PATIENT INTAKE

Pain Description - Check all the following that describe of your pain

☐ Aching	☐ Numbness	☐ Spasms	☐ Throbbing
☐ Cramping	☐ Shock-like	☐ Squeezing	☐ Tingling/Pins & Needles
☐ Dull	☐ Shooting	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Hot/Burning			

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
☐ Bending Backward	☐	☐	☐
☐ Bending Forward	☐	☐	☐
☐ Changes in Weather	☐	☐	☐
☐ Climbing Stairs	☐	☐	☐
☐ Coughing / Sneezing	☐	☐	☐
☐ Driving	☐	☐	☐
☐ Lifting Objects	☐	☐	☐
☐ Looking Forward	☐	☐	☐
☐ Looking Downward	☐	☐	☐
☐ Looking Side to Side	☐	☐	☐
☐ Rising from a Seated Position	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Walking	☐	☐	☐

What other factors worsen or affect you pain that is not listed above? _____

Pain Treatment History

Please mark and list what previous pain treatments you have had (approximate dates):

☐ I **Have Not Had Any Prior Treatments for My Current Pain Complaints**

☐ Physical Therapy How many sessions?_____ Date: _____

☐ Chiropractic How many sessions?_____ Date: _____

☐ Injection Therapy If so, list:_____ Date: _____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

_____

_____

☐ I **Have Not had any Surgical Procedures Performed**

INNOVATIVE INJURY SOLUTIONS NEW PATIENT INTAKE

Social History

Are you capable of becoming pregnant? □ Yes □ No If so, are you currently pregnant? □Yes □ No

Highest level of education obtained: □ Grammar □ High School □ College □ Post-Graduate

Alcohol Use: □ Current Alcoholism □ Daily Limited Alcohol Use □ History of Alcoholism
□ Never Drinks Alcohol □ Social Alcohol Use

Tobacco Use: □ Current Tobacco Use □ Former Tobacco User □ Never Used Tobacco

Current Medications

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you taking a prescribed **blood-thinner** medication? □ Yes □ No If yes, please list: _____

Allergies

Do you have any known drug allergies? □ Yes □ No If so, please list all medications you are allergic to:

Medication Name:	**Allergic Reaction Type:**
_____	_____
_____	_____

Please check if you are allergic to: ☐ Iodine or ☐ Tape

***Areyouallergictolatex?** ☐ Yes ☐ No

INNOVATIVE INJURY SOLUTIONS NEW PATIENT INTAKE

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer - Type
☐ Diabetes - Type
☐ HIV/AIDS

Head/Eyes/Ears/Nose/Throat

☐ Glaucoma
☐ Headaches
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Migraines

Cardiovascular/Hematologic

☐ Anemia
☐ Bleeding Disorders
☐ Coronary Heart Disease
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Murmur
☐ Pacemaker/Defibrillator
☐ Phlebitis
☐ Poor Circulation
☐ Stroke

Respiratory

☐ Asthma
☐ Bronchitis
☐ Emphysema/COPD
☐ Pneumonia
☐ Tuberculosis
☐ Valley Fever

Gastrointestinal

☐ Bowel Incntinence
☐ Acid Reflux/GERD
☐ Gastrointestinal Bleeding
☐ Constipation

Musculoskeletal

☐ Amputation
☐ Bursitis
☐ Carpel Tunnel Syndrome
☐ Chronic Low Back Pain
☐ Chronic Neck Pain
☐ Chronic Joint Pain
☐ Fibromyalgia
☐ Joint Injury
☐ Osteoarthritis
☐ Osteoporosis
☐ Phantom Limb Pain
☐ Rheumatoid Arthritis
☐ Tennis Elbow
☐ Vertebral Compression Fracture

Genitourinary/Nephrology

☐ Bladder Infection(s)
☐ Dialysis
☐ Kidney Infection(s)
☐ Kidney Stones
☐ Urinary Incontinence

Hepatic

☐ Hepatitis A (active/inactive/unsure)
☐ Hepatitis B (active/inactive/unsure)
☐ Hepatitis C (active/inactive/unsure)

Neuropsycholigical

☐ Alcohol Abuse
☐ Alzheimer Disease
☐ Bipolar Disorder
☐ Depression
☐ Epilepsy
☐ Prescription Drug Abuse
☐ Multiple Sclerosis
☐ Paralysis
☐ Peripheral Neuropathy
☐ Schizophrenia
☐ Seizures
☐ Reflex Sympathetic Dystrophy/ CRPS

☐ **Other Diagnosed Condition:**

Notice of Medical Lien

Name: _____Date of Birth: _____Date of Accident:_____

I, _____ do hereby consent to receiving medical services from Innovative Injury Solutions (IIS) which includes any assigned employee(s) or independent contractor(s) of Innovative Injury Solutions.

For good and valuable consideration received authorize and direct the insurance company (1st party medical payment benefits, personal injury protection, and/or un/under-insured coverage; and/or 3rd party coverage ~ e.g., at-fault insurance company; and/or other covered insurance) to pay directly ton Innovative Injury Solutions as sums as may be due and owing this office for services rendered me, by reason of this accident , and to withhold such sums from any disability benefits, medical benefits, no-fault benefits, health and/or accidental benefits, workers compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Innovative Injury Solutions.

I hereby authorize and direct my attorney and/or legal firm (if represented) to pay directly to Innovative Injury Solutions such sums as may be due and owing for medical services rendered me by reason of this accident and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect Innovative Injury Solutions. I hereby further give a lien on my case to Innovative Injury Solutions against all proceeds of any settlement or judgement that may be paid to my attorney(s) or myself as the result of injuries in connection herewith. I understand no settlement, verdict, or judgement proceeds can be dispersed to me without first satisfying this lien. I agree to fully protect Innovative Injury Solutions by disallowing the use of common/general fund dispersal and/or a reduction based upon LaBombard v Samaritan Health System (195 AZ 543,991 P.2nd App. 1998) or Andrews v Samaritan Health System (201 AZ 379,36 P.3d 57 App. 2001).

In consideration of Innovative Injury Solutions waiting for payment, including but not limited to any applicable co-payments, co-insurance or deductibles, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. I understand and authorize the use of balance billing if Innovative Injury Solutions deems necessary, to be utilized to acquire the balance owed. I understand that Innovative Injury Solutions can, at any time, request the balance owed to be paid and if the balance is not paid when requested, Innovative Injury Solutions may use any collection method available to help secure the outstanding balance.

I fully understand that I remain directly and fully responsible to Innovative Injury Solutions for all medical bills submitted for services rendered me and on my behalf in preparing my case for trial or settlement that this agreement is made solely for Innovative Injury Solution's additional protection and in consideration of Innovative Injury Solution waiting for payment. I direct that this lien will remain valid even if I change attorneys or choose to represent myself regarding the claim(s).

_____ _____

Patient Signature Date Signed

Name: _____ DOB: _____Date of Accident: _____

I do hereby consent to receiving medical services from National Imaging Centers (NIC) which includes any assigned employee(s) or independent contractor(s) of National Imaging Centers.

For good and valuable consideration received authorize and direct the insurance company (1st party medical payment benefits, personal injury protection, and/or un/under-insured coverage; and/or 3rd party coverage ~ e.g., at-fault insurance company; and/or other covered insurance) to pay directly to National Imaging Centers as sums as may be due and owing this office for services rendered me, by reason of this accident , and to withhold such sums from any disability benefits, medical benefits, no-fault benefits, health and/or accidental benefits, workers compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said National Imaging Centers.

I hereby authorize and direct my attorney and/or legal firm (if represented) to pay directly to National Imaging Centers such sums as may be due and owing for medical services rendered me by reason of this accident and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect National Imaging Centers. I hereby further give a lien on my case to National Imaging Centers against all proceeds of any settlement or judgement that may be paid to my attorney(s) or myself as the result of injuries in connection herewith. I understand no settlement, verdict, or judgement proceeds can be dispersed to me without first satisfying this lien. I agree to fully protect National Imaging Centers by disallowing the use of common/general fund dispersal and/or a reduction based upon LaBombard v Samaritan Health System (195 AZ 543,991 P.2nd App. 1998) or Andrews v Samaritan Health System (201 AZ 379,36 P.3d 57 App. 2001).

In consideration of National Imaging Centers waiting for payment, including but not limited to any applicable copayments, co-insurance or deductibles, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. I understand and authorize the use of balance billing if National Imaging Centers deems necessary, to be utilized to acquire the balance owed. I understand that National Imaging Centers can, at any time, request the balance owed to be paid and if the balance is not paid when requested, National Imaging Centers may use any collection method available to help secure the outstanding balance.

I fully understand that I remain directly and fully responsible to National Imaging Centers for all medical bills submitted for services rendered me and on my behalf in preparing my case for trial or settlement that this agreement is made solely for National Imaging Center's additional protection and in consideration of National Imaging Center waiting for payment. I direct that this lien will remain valid even if I change attorneys or choose to represent myself regarding the claim(s).

Patient Signature: _____ Today's Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Innovative Injury Solutions

1921 S Alma School Rd, 110

Mesa, AZ 85210

Phone: 480-573-0414 / Fax: 480-573-0413

Patient's name: _____ Date of Birth: _____

I request and authorize: _____ to release healthcare information of the patient named above to Innovative Injury Solutions:

PHONE: _____FAX: _____

Description of Protected Health Information to be disclosed:

☒ Last 3 office visit notes ☒ All diagnostic reports ☒ Other: All procedure/surgical notes

Purpose(s) of the disclosure:

☒ Continuity of Care ☐ Transfer of Care ☐ Other: _____

I hereby authorize Provider to release Protected Health Information ("Information") to Innovative Pain and Wellness. I understand that this authorization may cover information relating to: (I) AIDS, HIV, and other communicable diseases; (II) genetic testing; (III) psychiatric, mental, and behavioral health and treatment; and (IV) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying the Provider in writing. I understand that any disclosure made pursuant to this authorization before, and revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eight (180) days following the date of execution. I understand that a photocopy of facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____ _____

Signature of Patient or Patients Legal Representative Date

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient:

_____

INNOVATIVE INJURY SOLUTIONS™

Croft-Dawe Post Concussion Questionnaire (CD-PCQ)

Name:	ID:
D.O.B.	Date:
Sex:	Date of Accident:
Phone:	Email Address:

After a sustaining whiplash and/or a head injury many people experience symptoms that can disrupt their daily lives. Please mark "**Yes**" to all the symptoms below that you have experienced and continue to experience since the accident.

	Yes	No	
			Somatic Symptoms
1	☐	☐	More frequent headaches or more intense headaches compared to before the accident.
2	☐	☐	Become tired or fatigued more easily compared to before the accident.
3	☐	☐	Experience Nausea and/or vomiting
4	☐	☐	Feeling dizzy more frequently than before the accident.
5	☐	☐	Don't feel rested after a full night's sleep.
			Neurological Symptoms
6	☐	☐	Experience blurred vision.
7	☐	☐	Vision is worse than compared to before the accident.
8	☐	☐	Occasionally experience double vision.
9	☐	☐	More restless than before the accident.
10	☐	☐	Feel more unstable on your feet than compared to before the accident.
11	☐	☐	Coordination is worse than before the accident.
12	☐	☐	Experience numbness or tingling down the arms or legs.
13	☐	☐	Noticed changes to taste or smell since the accident.
14	☐	☐	Noticed that its more difficult to say certain words.
15	☐	☐	Noticed that swallowing is different or more difficult than compared to before the accident.
16	☐	☐	More sensitive to noise compared to before the accident.
17	☐	☐	More sensitive to light compared to before the accident.
			Neuropsycholigical Symptoms
18	☐	☐	Have difficulty falling asleep compared to before the accident.
19	☐	☐	Have difficulty staying asleep compared to before the accident.
20	☐	☐	Wake up early in the morning and are unable to go back to sleep compared to prior to the accident.
21	☐	☐	Have more nightmares than compared to prior to the accident.
22	☐	☐	Feel more irritable than before the accident.
23	☐	☐	Become more frustrated or irritated easier compared to before the accident.
24	☐	☐	Are more forgetful than before the accident.
25	☐	☐	Have more difficulty concentrating compared to before the accident.
26	☐	☐	Noticed that you daydream more often than before the accident.
27	☐	☐	Noticed you are sadder or become sad more easily than before the accident.
28	☐	☐	Noticed that you are more anxious or become anxious more easily than before the accident.

If one or more symptoms are marked in two of the three categories, refer the patient for a neurological consult with Innovative Injury Solutions.

Phone: (480) 306-7242 **Email:** referrals@innovativeinjurysolutions.com

INNOVATIVE INJURY SOLUTIONS NEW PATIENT INTAKE

Patient Name:_____
(Please print)

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Innovative Injury Solutions has the right to change its Notice of Privacy Practices from time to time and that I may contact Innovative Injury Solutions at any time to obtain a current copy.

****Signature**: _____Date: _____

Acceptance of Medical Lien:

I have read, understand, and agree to the provisions of the Medical Lien.

****Signature**: _____Date: _____

Notice of Electronic Access to Prescription History:

By signing below, I authorize Innovative Pain and Wellness to obtain my medication history from my pharmacy electronically.

****Signature**: _____Date: _____

Notice of Diagnostic Release:

By signing below, I authorize Innovative Injury Solutions to release my current diagnosis to my pharmacy to validate my need for pain management prescriptions and to secure such as needed.

****Signature**: _____Date: _____

Authorization of Release of Health Information:

I hereby authorize Innovative Injury Solutions and its Employees permission to discuss, send and/or receive my personal health information **to/with the following individual(s):**

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

I further authorize Innovative Injury Solutions to release any medical or incidental information to my referring physician/Attorney or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

****Signature**: _____Date: _____