BioFXN
Personalized Innovative Healthcare

Dr. Anna Martin, ND
*Functional Medicine Doctor*

*Powered by Rebound SportsMed*

# NOTICE OF DOCTOR LIEN

Patient: _____ Date: _____

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the 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 such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate BioFXn, PLLC via Rebound SportsMed. And I hereby further give a Lien on my case to BioFXn, PLLC via Rebound SportsMed against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to BioFXn, PLLC via Rebound SportsMed for all medical bills submitted for service rendered me. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____

DATED PATIENT'S SIGNATURE

_____ _____

DATED OFFICE SIGNATURE

# AUTO ACCIDENT INTAKE

NAME: _____ Date:_____

DATE OF BIRTH: _____

AUTO INSURANCE: _____

CLAIM NUMBER #: _____

ADJUSTER: _____

| | Yes | No |
|---|---|---|
| Have you retained an attorney? | ☐ | ☐ |

Name/Telephone: _____

**Nature of Accident**

Date of Accident: _____ Time: _____ Vehicle: _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of People in Your Vehicle: _____ Other Vehicle: _____

Direction you were headed: ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

Direction other vehicle headed: ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

Were you knocked unconscious?: ( ) Yes ( ) No. If yes, for how long?: _____

In your own words, please describe the accident _____

_____

_____

Did you have physical complaints BEFORE the accident? ( ) Yes ( ) No

If yes, please describe in detail: _____

_____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Do you have any previous injuries/illnesses which relate to this case?: _____

_____

Have you ever been involved in an accident before?: ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

Where were you taken after the accident?: _____

Have you been treated by another doctor(s) since the accident?: ( ) Yes ( ) No. If yes, please list doctor's name(s): _____

What type of treatment did you receive?: _____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

**Check Symptoms You Have Noticed Since The Accident:**

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

Symptoms other than above: _____

Have you lost time from work as a result of this accident?: ( ) Yes ( ) No. If yes, please complete the following

Last Day Worked: _____

Type of Employment: _____

Did you notice any activity restrictions as a result of this injury?:( ) Yes ( ) No. If yes, please describe in detail:

_____

_____

_____

Please list any other pertinent information:

_____

_____

_____

_____

# Your Health History

*Please take the time to fill in this information. It really helps streamline our time together.*

Name: _____ Date:_____

Age: _____ Date of Birth: _____ Occupation: _____

How long has it been since your last medical evaluation?: _____
Do you follow any special diet? If yes, please describe: _____

| | Yes | No | |
|---|---|---|---|
| Tobacco? | ☐ | ☐ | If yes, how much/many per day? _____ for how many years have you used tobacco? _____ |
| Alcohol? | ☐ | ☐ | If yes, how many drinks per week? _____ |
| Caffeinated drinks? | ☐ | ☐ | How many per day? _____ |
| Regular exercise? | ☐ | ☐ | Please describe: _____ _____ |

Please list any **allergies** or **sensitivities** to medications: Tic here if none: ☐

| **Allergy:** | **Type of reaction:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If you have personal reasons to not receive blood products, please tick here: ☐

**Current Medications** (prescription & non-prescription, please include dose):

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Herbs or supplements**

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Personal Medical History:** *Please tick the appropriate box*

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| High blood pressure: | ☐ | ☐ | Gastrointestinal disorder: | ☐ | ☐ |
| Cholesterol problems: | ☐ | ☐ | Acid reflux: | ☐ | ☐ |
| Heart disease: | ☐ | ☐ | Stomach ulcer: | ☐ | ☐ |
| type: _____ | | | Hepatitis: | ☐ | ☐ |
| Thyroid disorder: | ☐ | ☐ | Irritable bowel | ☐ | ☐ |
| Diabetes: type: _____ | ☐ | ☐ | Frequent bladder infections: | ☐ | ☐ |
| Kidney disease: | ☐ | ☐ | Incontinence: | ☐ | ☐ |
| Anemia: | ☐ | ☐ | Respiratory problems: | ☐ | ☐ |
| Bleeding/clotting disorder: | ☐ | ☐ | Asthma: | ☐ | ☐ |
| Stroke: | ☐ | ☐ | Seasonal allergies: | ☐ | ☐ |
| Skin disorder: | ☐ | ☐ | Sleep problems: | ☐ | ☐ |
| type: _____ | | | Serious infections: | ☐ | ☐ |
| Cancer: | ☐ | ☐ | Chronic pain: | ☐ | ☐ |
| type: _____ | | | location of pain: _____ | | |

Other illnesses: _____

Please list any **surgeries**: _____

_____

Have you had any recent **accidents**? Yes ☐ No ☐

If yes, please describe: _____

Do you have a tendency for depression? Yes ☐ No ☐

If yes, what treatment has been helpful? _____

**Family History:**

| | relationship to you | | relationship to you |
|---|---|---|---|
| Diabetes | _____ | Alcoholism | _____ |
| Heart disease | _____ | Depression | _____ |
| High blood pressure | _____ | Bleeding disorder | _____ |
| High Cholesterol | _____ | Strokes | _____ |
| Prostate cancer | _____ | Arthritis | _____ |
| Breast cancer | _____ | Thyroid disease | _____ |
| Other cancers | _____ | Osteoporosis | _____ |

Please specify any specific issues or problems you would like to address today:

_____

_____

_____

_____