Accident & Wellness Chiropractic

4124 SE 82nd Ave, Ste. 700
Portland, OR 97266
(503) 206-8863

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Information

Name: ____Date of Birth____________ Age: __________

Address: ____

Email: ____

Phone: ___________________________________ Cell: _________________________ Work: ___________

O Male O Female

Marital Status: O Married O Single O Divorced O Separate o Other

Insurance name_____________________________Claim # ______________________________________

Occupation_________________________________Employer____________________________________

Name of spouse or nearest relative: _____________________________ Phone______________________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Date of Injury: _________________ **Time:** ___________________ **Location:** ___________________

Vehicle Type Model:______________________________ Year:____________ Size: __________________

Your position in the vehicle:

O Driver

O Passenger _______ Location _______ **O** Left **O** Middle **O** Right

O Other: _________________ **O** Front passenger **O** Rear passenger **O** Third Seat (rear)

Speed of your vehicle:

O Stopped **O** Moving moderately

O Parked **O** Moving fast

O Slowing **O** Moving at apprx _______ MPH

O Moving slowly

Why vehicle was slowed or stopped:

O Traffic Signal **O** Parking

O Pedestrian **O** Traffic

O Stop sign **O** Busy intersection

Collision Type:

O Driver side impact **O** Head on collision

O Passenger side impact **O** Rear impact

O Front impact **O** Pedestrian incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle Type: Model: ______________________________ Year: ______________ Size: __________________

CONDITIONS AT THE TIME OF THE ACCIDENT:

TIME OF DAY COMPROMISED BY:	ROAD CONDITIONS		VISIBILITY
O Full daylight	**O** Dry	**O** Excellent	**O** Bright
O Dawn	**O** Damp	**O** Good	**O** Dark
O Dusk	**O** Wet	**O** Fair	**O** Rain
O Night	**O** Snow covered	**O** Poor	**O** Snow
	O Ice covered		**O** Fog
	O Patchy ice/snow		**O** Traffic

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THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you:

O Totally unaware that the accident was impending
O Aware of impending accident
O Aware of impending accident and braced for it

Restraints (check all that apply):

O Seat belt
O Shoulder harness
O No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? **O** Yes **O** No **O** Knocked off by impact

Was the air bag deployed?

O Car not equipped with air bag
O Air bag deployed
O Air bag not deployed

Position of YOUR head during impact?

O Facing straight ahead
O Tilted forward
O Rotated to the left
O Rotated to the right

Position of your body during impact?

O Straight
O Tilted forward
O Rotated to the left
O Rotated to the right

Damage to vehicle YOU were in:

O Incurred minimal damage
O Incurred moderate damage
O Incurred severe damage
O Totaled
O Not known

What position was YOUR headrest in?

O High position
O Middle position
O Low position

Was your head thrown...?

O Backward then forward
O Forward then backward
O To the left **O** To the left then right
O To the right **O** To the right then left

Was your body thrown...?

O Backward then forward **O** Across the vehicle
O Forward then backward **O** Outside the vehicle
O To the left **O** To the left then right
O To the right **O** To the right then left
O Under the vehicle

Citations:

O None issued
O Yourself
O Driver of vehicle patient was a passenger of
O Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

1._________________ 2.__________________ 3. _________________ 4. ________________5.________________

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

O Yes
O No

Immediately following the accident, did you feel...?

O Dizzy **O** Weak **O** Nauseated
O Dazed **O** Nervous **O** Disoriented

Were you able to walk unaided?

O Yes **O** No

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Where did you go?

O Drove home	O Drove to work	O Taken to hospital via ambulance
O Was driven home	O Was driven to work	O Was driven to hospital
O Drove to hospital	O Drove to school	O Was driven to school

Next day discomfort?

O Increased O Decreased O Same

Did your major complaints exist before the accident?

O Yes O No

In what areas did you IMMEDIATELY feel pain?

O Head	Shoulder	O Left	O Right	Hip	O Left	O Right
O Neck	Arm	O Left	O Right	Thigh	O Left	O Right
O Upper back	Elbow	O Left	O Right	Knee	O Left	O Right
O Mid back	Wrist	O Left	O Right	Calf	O Left	O Right
O Ribs	Hand	O Left	O Right	Ankle	O Left	O Right
O Chest	Fingers	O Left	O Right	Toes	O Left	O Right
O Abdomen	Buttock	O Left	O Right	Foot	O Left	O Right
O Low back	Pelvis					

Where did you experience pain on the day FOLLOWING the accident?

O Head	Shoulder	O Left	O Right	Hip	O Left	O Right
O Neck	Arm	O Left	O Right	Thigh	O Left	O Right
O Upper back	Elbow	O Left	O Right	Knee	O Left	O Right
O Mid back	Wrist	O Left	O Right	Calf	O Left	O Right
O Ribs	Hand	O Left	O Right	Ankle	O Left	O Right
O Chest	Fingers	O Left	O Right	Toes	O Left	O Right
O Abdomen	Buttock	O Left	O Right	Foot	O Left	O Right
O Low back	Pelvis					

Medical / Family History **S = Self** **M = Mother** **F = Father**

Please indicate which conditions have been experienced by the above by marking appropriate circles

S M F		S M F		S M F	
O O O	AIDS	O O O	Dislocated joints	O O O	Neck pain
O O O	Anemia	O O O	Epilepsy	O O O	Nervousness
O O O	Arthritis	O O O	Measles	O O O	Numbness
O O O	Asthma	O O O	Headaches	O O O	Polio
O O O	Back Pain	O O O	Heart trouble	O O O	Poor circulation
O O O	Bladder trouble	O O O	Reproductive disorder	O O O	Hepatitis
O O O	Bone fracture	O O O	High blood pressure	O O O	Rheumatic fever
O O O	Cancer	O O O	HIV / ARC	O O O	Rheumatism
O O O	Chest pain	O O O	Kidney disorder	O O O	Scarlet Fever
O O O	Concussion	O O O	Bowel control loss	O O O	Serious injury
O O O	Convulsions	O O O	Menstrual cramps	O O O	Sinus trouble
O O O	Diabetes	O O O	Multiple sclerosis	O O O	Tuberculosis
O O O	Indigestion	O O O	Muscular Dystrophy	O O O	Venereal disease

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Have you been treated by a physician for any health condition in the last year? **O** Yes **O** No
Describe the condition: ______________________________________Date of last Physical Exam: _____________
Have you ever had a metal implant? **O** Yes **O** No Ever been gunshot? **O** Yes **O** No
Do you drink alcohol? O Yes O No; if Yes, how often_______. Do you smoke? O Yes O No

Surgical History:
1. ____________________________ **Date:**____________
2. ____________________________ **Date:** ___________

Accident History:
O Job **O** Auto **O** Other: ________ Date: ________
O Job **O** Auto **O** Other: ________ Date: ________

Please describe present major complaints:
Please rate your symptom from 1-10 (1 being less serious)

1. _____________________________________ ______
2. _____________________________________ ______
3. _____________________________________ ______
4. _____________________________________ ______
5. _____________________________________ ______

Are you allergic to any medications? **O** Yes **O** No If yes, which? ________________________________
Are you taking any medication? **O** Yes **O** No If yes, which? ________________________________
Are you pregnant? **O** Yes **O** No Date of last menstrual period? __________________
Do you have children? **O** Yes **O** No If yes, what ages? _____________________________

Please check the following activities that aggravate your condition:
O Bending
O Coughing
O Sitting
O Walking
O Lying down
O Reaching
O Standing
O Sneezing
O Turning head
O Straining at stool

Please check the following activities that relieve your condition:
O Bending **O** Reaching **O** Turning head **O** Reaching **O** Walking

Please check any additional symptoms you may be experiencing:
O Blurred vision **O** Buzzing in ears **O** Cold feet **O** Cold hands **O** Cold sweats
O Loss concentration **O** Constipation **O** Depression **O** Diarrhea **O** Muscle jerking
O Flushed face **O** Fainting **O** Fatigue **O** Fever **O** Headaches
O Head feels heavy **O** Insomnia **O** Dizziness **O** Loss of smell **O** Numb fingers
O Ringing in ears **O** Loss of taste **O** Upset stomach **O** Sensitivity to light
O Pins and Needles in arms **O** Shortness of breath

Patient Signature: ____ **Date:** _______________________

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Accident & Wellness Chiropractic (AWC) and/or other licensed doctors of chiropractic who now or in the future render treatment for me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic of AWC. This authorization also extends to all office staff members of AWC.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I understand the purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I also understand that though the doctor will not diagnose or treat any disease or condition other than vertebral subluxation, he/she will advise me of any non-chiropractic or unusual findings and will recommend that I seek the services of healthcare providers who specialize in such areas for proper advice, diagnosis, or treatment of such findings.

I have read the above explanation of the chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

____
Printed name of patient

____ ________________________
Signature of patient Date

____ ________________________
Signature of Patient's representative (if minor or physically incapacitated) Date

____ ________________________
Witness to Patient's signature Date

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Accident & Wellness Chiropractic (AWC) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that AWC reserves the right to change the terms of this notice from time to time and that I may contact AWC at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that AWC is not required to agree to these requested restrictions. However, if AWC does agree, AWC is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature ______________________________________ Date ____________________

Printed Patient Name ____

Relationship to Patient ____

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FINANCIAL POLICY

1. Responsibility for Payment: We consider the patient to be responsible for payment of services. In cases where the patient is a minor, the parent that the child is living with is responsible for payment.

2. Insurance Billing: As a courtesy to you, we will bill your primary insurance company provided that the pertinent identification numbers are provided. It is the patient's responsibility to inform our office of ANY insurance changes.

3. Auto Insurance: If patient is involved in an automobile accident, the responsible party is the insured automobile the patient was in at the time of the accident. The patient is required by this office to fill out and sign all lien agreements.

4. Workers Compensation: If an injured worker has completed the appropriate forms in our office, we will bill his/her industrial accident insurance.

5. Major Medical Insurance: Please see the following regarding major medical insurance:

- If your annual insurance deductible has not yet been met, payment is expected at the time of service.
- Insurance is considered to be a private contract between the patient and insurance company: it is the patient's responsibility to resolve any difficulties with claims processing directly with the insurance company. We will call for benefits, but there is **NO GUARANTEE OF BENEFITS.**

6. All Insurance Claims: Any amount not covered by major medical insurance, auto insurance, workers compensation insurance is the **FULL RESPONSIBILITY** of the patient or patient's guardian.

I, ____ , have read this financial policy and understand its content.

____ ____________________________

Signature of Patient/Guardian **Date**

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Medical Records Release Form

I hereby authorize Physician:

Physician name: ____

Clinic / Hospital: ____

Street Address: ____

City: ______________________ State: ____________ Zip: ________

Phone Number: ______________________ Fax: ____________________

To release any Medical information to: Accident & Wellness Chiropractic

Dates of services to be included: ____________________________________

Print patient's name: ____

Maiden or other name: ____

Patient Phone number: ____

Date of birth: ____

I hereby release the facility, physicians, and its employees from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized above.

Patient's Signature: ______________________________ Date: ____________

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Doctor's Lien and Assignment of Right to Recovery

I do hereby authorize Accident & Wellness Chiropractic (AWC) to furnish my attorney and/or insurance carrier, with information regarding the accident in which I was involved.

I understand that I am directly responsible to AWC for any and all bills submitted for services. I further understand that such payments is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. In consideration to not having to immediately pay debt, I hereby assign and convey to AWC a legal and equitable interest in any and all causes of action of rights of recovery. I also understand that a nine percent interest charge will be accrued to any balance held over ninety days until my balance is zero.

I hereby authorize my attorney, and insurance company to pay directly to AWC, that which is owing for professional services as a result of this accident and by reason of any other bills that are due to AWC including attorney fees. These are to be withheld from any settlement or judgment. I hereby further give a lien on my case to AWC against any and all proceeds of my settlement, judgment or verdict which may be paid to you as a result of the injuries for which I have been treated.

I further instruct a separate check to be issued to AWC for services rendered.

I have read this document, I understand it, and I voluntarily agree to be bound by it. I am directing my attorney to protect AWC's interest as provided herein.

______________________________	____	______________
Patient Name (Print)	Patient Signature	Date

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 adequately to protect AWC.

______________________________	____	______________
Attorney Name (Print)	Attorney Signature	Date