CONFIDENTIAL PATIENT INFORMATION FOR AUTO ACCIDENTS

NAME:______________________________ DATE:______________________

HOME PHONE:______________________________WORK PHONE:______________________

STREET ADDRESS:____

CITY/STATE:______________________ZIP:__________P.O. BOX______________

AGE:__________DATE OF BIRTH:______________# OF CHILDREN:______________

MARITAL STATUS: **S M W D**

NAME OF EMPLOYER:____

OCCUPATION:______________HOW DID YOU HEAR ABOUT US?______________________

NAME OF SPOUSE:______________________OCCUPATION:______________________

NEAREST RELATIVE:______________________PHONE:______________________

ADDRESS:____

CITY/STATE:______________________ZIP CODE:______________________

ARE YOU PREGNANT ? **YES NO** PLEASE INITIAL HERE______________

IS THERE ANY HISTORY OF CANCER IN YOUR FAMILY ? **YES NO**

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER ? **YES NO**

IF YES, WHEN AND WHAT TYPE: ____

DATE OF ACCIDENT:______________________TIME OF ACCIDENT:______________________AM/PM

CITY OF ACCIDENT:______________________STREET OF ACCIDENT:______________________

ROAD CONDITION AT THE TIME OF THE ACCIDENT: **WET DRY ICY OTHER:**______________

DID THE POLICE COME TO THE SCENE? **YES NO** IS THERE A POLICE REPORT? **YES NO**

ACCIDENT SYMPTOMS	SEVERITY (0=NO PAIN 10=EMERGENCY)
1.______________________________	______
2.______________________________	______
3.______________________________	______
4.______________________________	______
5.______________________________	______

DID YOU GO TO THE HOSPITAL ? **YES NO**

IF YES, WHAT IS THE NAME AND CITY OF THE HOSPITAL?______________________

HOW DID YOU GET TO THE HOSPITAL?______________________

WHAT PARTS OF THE BODY WERE X-RAYED AT THE HOSPITAL?______________________

WHAT DID THE HOSPITAL DO FOR YOUR INJURIES?______________________

HOW LONG DID YOU STAY AT THE HOSPITAL?______________________

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WHAT BLEEDING CUTS DID YOU SUSTAIN DURING THE ACCIDENT?______________________________

WHAT BRUISES DID YOU SUSTAIN DURING THIS ACCIDENT?______________________________

WHERE WERE YOU SEATED IN THE VEHICLE?______________________________

WERE YOU AWARE OF THE APPROACHING COLLISION PRIOR TO IMPACT, OR DID IMPACT CATCH YOU BY SURPRISE?

AWARE **SURPRISE**

WHERE WERE YOU LOOKING AT THE TIME OF IMPACT?

STRAIGHT AHEAD **DOWN** **TO THE RIGHT** **TO THE LEFT** **OVER THE SHOULDER**

DID YOU LOSE CONSCIOUSNESS UPON IMPACT? **YES** **NO** IF YES, HOW LONG?__________________

DID YOU EXPERIENCE A FLASH OF LIGHT OR EXPLOSION IN YOUR HEAD? **YES** **NO**

DID YOU BECOME: **CONFUSED** **DISORIENTED** **LIGHT HEADED** **DIZZY** **NAUSEATED**

EXPERIENCE BLURRED VISION **RINGING/BUZZING IN EARS** FROM THE ACCIDENT?

IF YOU STILL HAVE ANY OF THOSE SYMPTOMS, WHICH ONES?______________________________

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE)

DIFFICULTY CONCENTRATING **IRRITABLE** **RESTLESSNESS**

DIFFICULTY WITH MEMORY **SLEEPLESSNESS** **FORGETFULNESS**

REDUCED TOLERANCE TO HEAT **REDUCED TOLERANCE TO ALCOHOL**

HOW FAR IS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD?

APPROXIMATELY ____________INCHES **ABOVE** **BELOW**

WERE YOU WEARING A SEATBELT? **YES** **NO** IF YES, WAS IT A **LAPBELT** **SHOULDER-LAP BELT**

LIST THE YEAR______________MAKE____________________AND MODEL_____________________OF VEHICLE.

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? **YES** **NO**

IF YES, WAS THE DRIVER'S FOOT ALSO ON THE BRAKE? **YES** **NO**

IF NO, PLEASE ESTIMATE THE SPEED OF THE VEHICLE YOU WERE IN: __________MPH

IF YOUR VEHICLE WAS MOVING AT THE TIME OF IMPACT, WAS IT:

SLOWING DOWN? **YES** **NO** GAINING SPEED? **YES** **NO** TRAVELING AT A STEADY RATE? **YES** **NO**

ON WHAT PART OF THE AUTOMOBILE DID ANY OF THE FOLLOWING BODY PARTS HIT?

HEAD HIT______________________________CHEST HIT______________________________

RIGHT/LEFT SHOULDER HIT______________________RIGHT/LEFT ARM HIT______________________

RIGHT/LEFT HIP HIT __________________________RIGHT/LEFT LEG HIT______________________

RIGHT/LEFT KNEE HIT _________________________OTHER:_____________________________

CONFIDENTIAL PATIENT INFORMATION FOR AUTO ACCIDENTS

DID YOU RECEIVE ANY INJURY OR BRUISE FROM THE SEAT BELT? **YES** **NO**

IF YES, PLEASE DESCRIBE:____

WAS THE TRUNK OF YOUR BODY POINTED FORWARD AT THE TIME OF THE COLLISION? **YES** **NO**

IF NO, HOW WAS IT TURNED?____

WAS YOUR HEAD POINTED STRAIGHT FORWARD? **YES** **NO** IF NO, WHAT DIRECTION WAS IT TURNED AND BY HOW MUCH?____

WHAT IS THE ESTIMATED COST OF THE DAMAGE TO THE VEHICLE YOU WERE IN? $____________________

WHICH OF THE FOLLOWING CAR PARTS BROKE DURING THE ADDICENT?

WINDSHIELD____________________FRONT SEAT________________

RIGHT/LEFT SIDE WINDOW__________OTHER____________________

STEERING WHEEL_________________OTHER ___________________

WHAT WAS THE YEAR_____________MAKE_____________AND MODEL_______________OF THE OTHER VEHICLE?

WAS THE OTHER VEHICLE MOVING AT THE TIME OF THE COLLISION? **YES** **NO**

IF YES, WHAT WAS IT'S APPROXIMATE SPEED? ___________MPH

IF THE OTHER VEHICLE WAS MOVING AT THE TIME OF THE COLLISION, WAS IT:

SLOWING DOWN **GAINING SPEED** **TRAVELING AT A STEADY SPEED**

IMPORTANT – PLEASE DESCRIBE, TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT.

____

____

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CONFIDENTIAL PATIENT INFORMATION FOR AUTO ACCIDENTS

HAVE YOU SEEN ANY OTHER HEALTH CARE PROVIDERS FOR YOUR INJURIES? **YES** **NO**

WHO	DATE	TEST/TREATMENT

DID YOU GO TO ANY HEALTH PROVIDER THE DAY OF OR THE DAY AFTER THE INJURY? **YES** **NO**

IF YES, WHO_______________

IS ANYONE STILL TREATING YOU FOR YOUR INJURIES? **YES** **NO**

WHO	DATE	TEST/TREATMENT

WHAT DIAGNOSTIC TESTS HAVE YOU HAD? **MRI**__________ **CAT SCAN**__________ **X-RAYS**__________

WHAT PRESCRIPTION DRUGS ARE YOU CURRENTLY TAKING? **NONE**

DRUG	REASON	FREQUENCY	DOSAGE	DURATION	HELPING?

WHAT NON-PRESCRIPTION/OVER THE COUNTER DRUGS ARE YOU CURRENTLY TAKING? **NONE**

DRUG	REASON	FREQUENCY	DOSAGE	DURATION	HELPING?

PRIOR TO THIS ACCIDENT HAVE YOU BEEN INVOLVED IN ANY SIMILAR TYPES OF ACCIDENTS? **YES** **NO**

WHEN	DID YOU RECOVER	WHAT WERE YOUR RESIDUALS ?

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WORK HISTORY

AT THE TIME OF THIS INJURY DID YOU HAVE A JOB? **YES** **NO**

WHAT WAS THE NATURE OF YOUR JOB? ______________________________

____

HOW MUCH WORK DID YOU MISS? ______________________________

HAVE YOU RETURNED TO WORK YET? **YES** **NO**

HAVE YOU ATTEMPTED TO RETURN TO WORK YET? **YES** **NO**

DID YOU LOSE YOUR JOB BECAUSE OF YOUR INJURIES? **YES** **NO**

DID YOU CHANGE JOBS BECAUSE OF YOUR INJURIES? **YES** **NO**

OVERALL, AT THIS TIME IS YOUR CONDITION: **BECOMING WORSE** **REMAINING THE SAME** **IMPROVING**

IF IMPROVING, ESTIMATE APPROXIMATE OVERALL IMPROVEMENT TO DATE:

____

____

____

HAS YOUR INSURANCE COMPANY EVER BEEN NOTIFIED OF THE ACCIDENT? **YES** **NO**

WHAT IS THE NAME OF YOUR AUTO INSURANCE COMPANY? (or the driver in the car in which you were a passenger)

____

WHAT IS THE ADDRESS AND PHONE NUMBER TO THE INSURANCE COMPANY?

____

____

WHAT IS YOUR CLAIM NUMBER? ______________ POLICY NUMBER? ______________

WHAT IS THE NAME OF THE OTHER DRIVERS INSURANCE COMPANY?

____

ADDDRESS AND PHONE NUMBER?

____

____

WHAT IS YOUR CLAIM NUMBER? ______________ POLICY NUMBER? ______________

DID YOU HAVE AN ATTORNEY ADVISING YOU IN THIS CASE? **YES** **NO**

IF YES, WHAT IS HIS/HER NAME? ______________________________

ADDRESS AND PHONE NUMBER? ______________________________

____

ASSIGNMENT AND RELEASE

I UNDERSTAND AND AGREE ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO MY AND ANY HEALTH OR ACCIDENT INSURANCE POLIDIES ARE BETWEEN THE INSURANCE CARRIER AND MYSELF. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES. CHIROPRACTIC CARE CENTER WILL ASSIST IN PREPARING ANY NECESSARY FORMS OR REPORTS AND I AUTHORIAE THE CHIROPRACTOR TO RELEASE ANY INFORMATION REQUIRED.

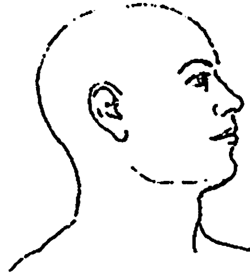
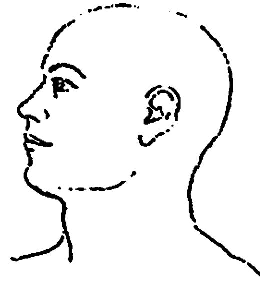
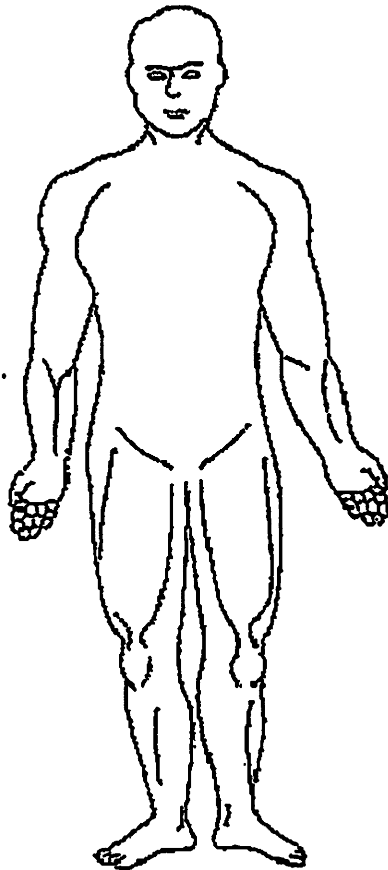
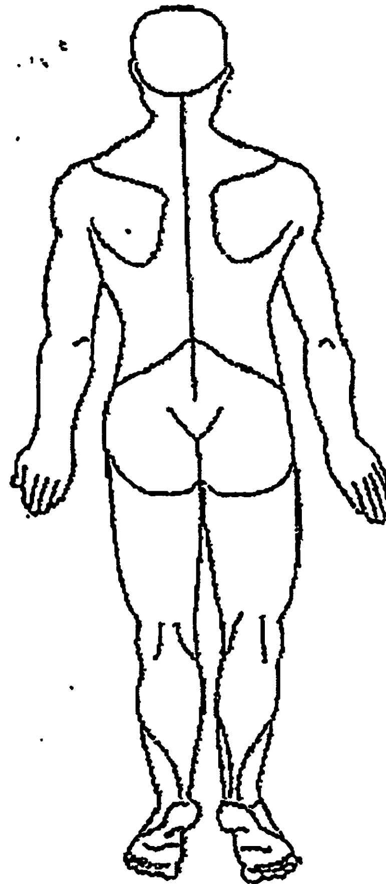
PATIENT'S SIGNATURE:____DATE:____________________

GUARDIANS SIGNATURE:____DATE:____________________

PAIN CHART

Please make the number on the drawing that most closely describes the sensations you feel. Use arrows to show radiating pain or odd sensations. Fill this out very accurately.

1. numbness
2. tingling
3. burning
4. ache
5. sharp
6. throbbing
7. stabbing
8. pins and needles

PATIENT SIGNATURE:________________________________ DATE:________________

FUNCTIONAL RATING INDEX

(FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY)

IN ORDER TO PROPERLY ASSESS YOUR CONDITION WE MUST UNDERSTAND HOW MUCH YOUR NECK AND/OR BACK PROBLEMS HAVE AFFECTED YOUR ABILITY TO MANAGE EVERYDAY ACTIVITIES. FOR EACH ITEM BELOW PLEASE CIRCLE THE NUMBER THAT MOST CLOSELY DESCRIBES YOUR CONDITION RIGHT NOW.

1. PAIN INTENSITY

0	1	2	3	4
NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN

2. SLEEPING

0	1	2	3	4
PERFECT SLEEP	MILDLY DISTURBED SLEEP	MODERATELY DISTURBED SLEEP	GREATLY DISTURBED SLEEP	TOTALLY DISTURBED SLEEP

3. PERSONAL CARE (WASHING, DRESSING, ETC.)

0	1	2	3	4
NO PAIN, NO RESTRICTIONS	MILD PAIN, NO RESTRICTIONS	MODERATE PAIN NEED TO GO SLOWLY	MODERATE PAIN NEED SOME ASSISTANCE	SEVERE PAIN NEED 100% ASSISTANCE

4. TRAVEL (DRIVING, ETC.)

0	1	2	3	4
NO PAIN, ON LONG TRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVERE PAIN ON SHORT TRIPS

5. WORK

0	1	2	3	4
CAN DO USUAL WORK PLUS EXTRA WORK	CAN DO USUAL WORK NO EXTRA WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORKUNLIMITED

6. RECREATION

0	1	2	3	4
CAN DO USUAL ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVATES	CAN DO A FEW ACTIVITIES	CANNOT DO ANY ACTIVITIES

7. FREQUENCY OF PAIN

0	1	2	3	4
NO PAIN	OCCASIONAL PAIN 25% OF THE DAY	INTERMITTENT PAIN 50% OF THE DAY	FREQUENT PAIN 75% OF THE DAY	CONSTANT PAIN 100% OF THE DAY

8. LIFTING

0	1	2	3	4
NO PAIN WITH HEAVY WEIGHT	INCREASED PAIN WITH HEAVY WEIGHT	INCREASED PAIN WITH MODERATE WEIGHT	INCREASED PAIN WITH LIGHT WEIGHT	INCREASED PAIN WITH ANY WEIGHT

9. WALKING

0	1	2	3	4
NO PAIN ANY DISTANCE	INCREASED PAIN AFTER 1 MILE	INCREASED PAIN AFTER ½ MILE	INCREASED PAIN AFTER ¼ MILE	INCREASED PAIN WITH ANY WALKING

10. STANDING

0	1	2	3	4
NO PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER 1 HOUR	INCREASED PAIN AFTER ½ HOUR	INCREASED PAIN WITH ANY STANDING

Name____ Total Score______

Printed

____ ________________

Signature Date

PERSONAL INJURY PROTECTION

WHAT IS PIP ?

Personal Injury Protection is part of your auto insurance policy. It is designed to take care of you immediately after an addicent.

ALWAYS USE YOUR PIP !

-PIP covers medical bills, a portion of your weekly lost wages, and for household care and cleaning.

-Your insurance company, by law, cannot cancel your policy for using your PIP and cannot increase your insurance rates for using your PIP.

-If you have not rejected PIP coverage in writing, then you are deemed to have it.

-Open your PIP claim immediately! If you wait you may find yourself paying for expensive medical bills out of your pocket until your claim is settled.

-PIP is no-fault. So it doesn't matter who caused the accident, you're still covered.

-PIP coverage is for 3 years or $10,000, which ever comes first. Some policies have higher limits.

-There is no deductible.

-If you have coverage on your auto policy, your medical bills get paid on time and you can maintain your treatment schedule uninterrupted.

A STEP-BY-STEP GUIDE:

-Call your insurance agent.

-Ask if you have PIP or MED PAY. If yes, ask about limits on time and dollar amount (3 years/$10,000).

-Ask your agent to take your Report of Loss claim.

-Ask your agent to phone in your report to the claims office.

-Ask your agent to call back with the claim number, address and phone number of the claims office.

-Call the claims office and get the name of the claims adjuster handling your claim.

-Ask the claims adjuster to mail a PIP Application, Attending Physician's Report and Salary Verification forms.

-Complete the PIP Application and return it to the claims adjuster.

-Have your doctor fill out the attending Physician's report and return it to you. Mail it to the claims adjuster.

-Provide your claim number and the adjuster's name, office address and phone number to all your Health Care Providers.

-Instruct your Health Care Providers to bill your PIP carrier directly, including copies of chart notes for each day of service.