Welcome to our office

Motor Vehicle Collision (MVC)

TODAY'S DATE: ___/___/_____

1. PATIENT INFORMATION (Please Print)

Name: _____

Address: _____

_____

CITY STATE ZIP

SEX M__ F__: DATE OF BIRTH: ___/___/___ AGE: _____

SINGLE___ MARRIED___ WIDOW___ DIVORCED___

SSN: _____-_____-_____

OCCUPATION: _____ FULL TIME___ ___PART TIME

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

SPOUSE'S NAME: _____

2. PHONE NUMBERS

H: _____ W: _____ EXT: _____

CELL: _____ ____ CHECK IF OK TO LEAVE MESSAGE ON YOUR CELL OR TEXT YOU WITH HIPPA PROTECTED INFORMATION

E-MAIL: _____

_____ CHECK IF OK TO CONTACT YOU VIS E-MAIL WITH HIPPA PROTECTED INFORMATION

WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY?

NAME: _____

RELATIONSHIP: _____

CELL: _____ WORK: _____ EMPLOYER: _____

WHO CAN WE THANK FOR REFERRING YOU HERE? _____

3. FINANCIAL INFORMATION:

ARE YOU THE PARENT OR LEGAL GUARDIAN OF THE PATIENT

___YES: NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION _____ NONE

INSURANCE COMPANY: _____

I.D. NUMBER: _____ GROUP: _____

PHONE NUMBER: _____

SUBSCRIBERS NAME: _____

DATE OF BIRTH: ___/___/___

RELATIONSHIP: _____

Date of Collision: ___/___/ ___ - Hour of Collision: _____ AM/PM

PLEASE DESCRIBE HOW THE COLLISION HAPPENED: _____

_____

4. SINCE THE MVC, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

___LOSS OF MOTION IN YOUR SPINE
___LOSS OF MOTION IN YOUR ARMS OR LEGS
___VISUAL DISTURBANCES: YES/NO
___ANXIETY: YES/NO
___DEPRESSION: YES/NO
___DIFFICULTY SLEEPING: YES/NO
___DIZZINESS: YES/NO

WHAT WAS YOUR POSITION IN THE CAR: ____ DRIVER; ____ FRONT PASSENGER; ____ LEFT REAR PASSENGER; ____RIGHT REAR
IF "DRIVER", WERE YOUR HANDS ON THE STEERING WHEEL? ____ BOTH; ____ RIGHT: ____ LEFT
DID THE AIRBAGS DEPLOY? ____ YES ____ NO

DID YOU STRIKE ANOTHER VEHICLE? ____ YES ____ NO DID ANOTHER VEHICLE STRIKE YOU? ____ YES ____ NO

ANGLE OF IMPACT: ____ FRONT ____ REAR-END ____ LEFT ____ RIGHT ____ OTHER: _____

IF SECOND COLLISION - ANGLE OF 2ND IMPACT: ___ FRONT ___ BACK ___ LEFT ___ RIGHT ___ OTHER

1. IN RELATION TO THE BACK OF YOUR HEAD; WAS YOUR HEADREST SET: ___ LOW ___ MIDDLE ___ HIGH
2. WERE YOU SURPRISED BY THE IMPACT? ___ YES ___ NO
   IF "NO", HOW DID YOU BRACE? ___ HANDS ___ FEET ___ BOTH
3. WHERE WAS YOUR HEAD FACING DURING IMPACT? ___ STRAIGHT AHEAD ___ LEFT ___ RIGHT ___ BEHIND

3A. WERE YOU LEANING FORWARD AT THE TIME OF IMPACT? ___ YES ___ NO

4. WHAT TYPE OF TYPE AND YEAR VEHICLE WERE YOU IN? _____

4A. WHAT WAS THE SPEED OF YOUR VEHICLE WHEN THE ACCIDENT OCCURRED? _____ MPH.

5. WHAT TYPE OF VEHICLE STRUCK YOU? _____

5B. WHAT WAS THE APPROXIMATE SPEED OF THE VEHICLE THAT STRUCK YOU? ____ MPH.

6. WERE YOU WEARING A SEATBELT? ___ YES ___ NO ___ LAP/SHOULDER
7. DID YOU FEEL IMMEDIATE PAIN FOLLOWING THE COLLISION? ___ YES ___ NO

WERE YOU RENDERED UNCONSCIOUS? ___ YES ___ NO

DID YOU STRIKE ANYTHING IN THE VEHICLE AT THE TIME OF IMPACT? ___ YES ___ NO
IF YES: ___ HEAD ___ CHEST ___ CHIN ___ SHOULDER ___ KNEES
ON WHAT? ___ STEERING WHEEL ___ WINDSHIELD ___ DASHBOARD
___ ROOF ___ LEFT SIDE DOOR ___ RIGHT SIDE DOOR
___ WINDOW ___ OTHER

DID YOUR SEAT BREAK OR BEND? ___ YES ___ NO

IMMEDIATELY FOLLOWING THE COLLISION, HOW DID YOU FEEL? (CHECK ALL THAT APPLY).
___ DIZZY ___ DAZED ___ WEAK ___ UPSET ___ DISORIENTED ___ NERVOUS ___ NAUSEOUS ___ OTHER

POLICE AND AMBULANCE

WAS THE ACCIDENT REPORTED TO THE POLICE? ___ YES ___ NO
WERE TRAFFIC CITATIONS ISSUED? ___ YES ___ NO
DID YOU GO TO HOSPITAL? ___ YES ___ NO
IF "YES" HOW DID YOU GET THERE? ___ AMBULANCE ___ PRIVATE TRANSPORTATION
WERE YOU ADMITTED? ___ YES ___ NO: IF YES, THEN FOR HOW LONG?
NAME OF HOSPITAL: _____ ATTENDED BY: _____
WHAT TREATMENT WAS GIVEN? (CHECK ALL THAT APPLY)
___ NONE ___ X-RAY ___ PAIN MEDICATIONS ___ STITCHES ___ MUSCLE RELAXANTS ___ BANDAGES ___ CERVICAL COLLAR
___ PHYSICAL THERAPY ___ INSTRUCTIONS ON CONCUSSIONS ___ INSTRUCTIONS ON SPRAINS AND STRAINS ___ FOLLOW UP

DO YOU HAVE DIFFICULTY: ___ STANDING ___ SITTING ___ WALKING ___ RIDING IN CAR ___ BENDING ___ TWISTING

IS YOUR PAIN/DISCOMFORT: ___ DULL ___ SHARP ___ BURNING ___ TINGLING ___ THROBBING ___ NUMBNESS ___ STABBING

AND IS IT? ___ MILD ___ MODERATE ___ SEVERE PAIN SCALE: MILD 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. SEVERE

HOW OFTEN DO YOU SUFFER FROM THIS? ___ DAILY, ___ TIMES PER WEEK, ___ TIMES PER MONTH, ___ TIMES PER YEAR

HOW LONG DOES IT LAST? _____ AND IS IT: ___ INTERMITTENT, ___ FREQUENT, ___ CONSTANT

DOES IT INTERFERE WITH: ___ WORK, ___ SLEEP, ___ DAILY ROUTINES, ___ RECREATION, ___ WALKING, ___ BENDING

WHAT HAVE YOU TRIED TO RELIEVE YOUR SYMPTOMS: _____

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6. PAST HEALTH HISTORY:

DO YOU HAVE ANY OF THE FOLLOWING? **Please check YES or NO for each condition:**

Relative Contraindications:

Articular Hypermobility Disease:	_ Yes _ No
Severe Demineralization of Bone:	_ Yes _ No
Benign Bone Tumor (Spine)	_ Yes _ No
Bleeding Disorder	_ Yes _ No
Are you taking Anticoagulants?	_ Yes _ No
Radiculopathy With Progressive Neurological Signs	
Radiating Pain, Numbness or Weakness into:	
_ Upper Extremities	_ Yes _ No
_ Lower Extremities	_ Yes _ No

Absolute Contraindications:

Rheumatoid Arthritis:	_ Yes _ No
Ankylosing Spondylitis:	_ Yes _ No
Fractures: _____	_ Yes _ No
Dislocations: _____	_ Yes _ No
Unstable OS (Odentoedum)	_ Yes _ No
Malignancies:	_ Yes _ No
Infection of bones or joints of the Vertebral Column	_ Yes _ No
Cauda Equina Syndrome	_ Yes _ No
Vertebrobasilar Insufficiency Syndrome	_ Yes _ No
Major Artery Aneurysm	_ Yes _ No

Previous Major illnesses or injuries: _____

Operations, Hospitalizations, Surgeries: _____

Medications you are currently taking: __ NONE

Allergies: _____ **Supplements:** _____.

FAMILY HISTORY – Immediate Family Members (Father, Mother, Brother, Sister)

Health status of family members: _____.

Are there any family members that suffer from?

__ Stroke __ Heart Disease __ Cancer __ Tumor __Degenerative Disc Disease __ Arthritis __ Osteoporosis __ other _____

If any of the above items are checked, then who in your family suffers? _____.

Are there any diseases that are "hereditary" or seem to run in your family? _____.

SOCIAL HISTORY – Please answer the following:

Please tell the doctor about your activities:

Exercise:
__ None
__ Occasional
__ Daily
__ Weekly
__ Other

Work/School
__ Sitting
__ Standing
__ Light Labor
__ Heavy Labor
__ Computer

Habits: __ None
__ Smoking - Packs Per Day __ None Drugs _____ None
__ Alcohol - Times Per Week ____ None
__ Caffeine: Coffee, Tea, Soda...Cups Per Day _____ None
Hobbies: _____ _____ None

Education:
_ High school
_ Some College
_ College Grad
_ Post Grad

7. REVIEW OF SYSTEMS:

PATIENT NAME: _____

HAVE YOU HAD ANY OF THE FOLLOWING ISSUES:

1. **PULMONARY (LUNG RELATED) ISSUES:**
__ ASTHMA/DIFFICULTY BREATHING; __ COPD; __ EMPHYSEMA; __ OTHER; __ NONE.

2. **CARDIOVASCULAR (HEART RELATED) ISSUES:**
__ HEART SURGERY; __ CHF; __ MURMURS/VALVE DISEASE; __ HEART ATTACK/MI; __ HEART DISEASE; __ HYPERTENSION; __ PACEMAKER; __ ANGINA/CHEST PAIN; __ IRREGULAR HEARTBEAT; __ OTHER; __ NONE.

3. **NEUROLOGICAL (NERVE RELATED):**
__ VISUAL CHANGES/LOSS OF VISION; __ ONE-SIDED WEAKNESS OF THE FACE OR BODY; __ HISTORY OF SEIZURES; __ ONE-SIDED DECREASED FEELING IN THE FACE OR BODY; __ HEADACHES; __ MEMORY LOSS; __ TREMORS; __ VERTIGO; __ LOSS OF SMELL/TASTE; __ STROKES/TIA'S; __ OTHER; __ NONE.

4. **ENDOCRINE (GLANDULAR/HORMONAL RELATED):**
__ THYROID DISEASE; __ HORMONE REPLACEMENT; __ INJECTABLE STEROIDS; __ DIABETES; __OTHER; __ NONE.

5. **RENAL (KIDNEY-RELATED):**
__ KIDNEY STONES; __ BLOOD IN URINE; __ INCONTINENCE; __ BLADDER INFECTIONS; __ DIFFICULTY URINATING; __ KIDNEY DISEASE; __ DIALYSIS; __OTHER; __ NONE.

6. **GASTROINTESTINAL (STOMACH-RELATED):**
__ NAUSEA; __DIFFICULTY SWALLOWING; __ ULCERATIVE DISEASE; __ ABDOMINAL PAIN; __ HIATAL HERNIA; __ CONSTIPATION; __ PANCREATIC DISEASE; __ IBS; __ HEPATITIS/LIVER DISEASE; __ BLOODY/BLACK TARRY STOOL; __ VOMITING BLOOD; __ BOWEL INCONTINENCE; __ REFLUX/HEART BURN; __ OTHER; __ NONE.

7. **HEMATOLOGICAL (BLOOD-RELATED):**
__ ANEMIA; __ REGULAR ANTIINFLAMMATORY USE (MOTRIN/IBUPROFEN/NAPROXEN/ALEVE); __HIV POSITIVE; __ ABNORMAL BLEEDING/BRUISING; __ SICKLE-CELL ANEMIA; __ ENLARGED LYMPH NODES; __ HEMOPHILIA; __REGULAR ASPRIN USE; __ HYPERCOAGULATION OR DEEP VEIN THROMBOSIS; __ HISTORY OF BLOOD CLOTS; __ ANTICOAGULENT; __ OTHER; __ NONE.

8. **DERMATOLOGICAL (SKIN-RELATED):**
__ PSORIATIC DISORDERS; __RASHES; __ BURNS; __ SKIN GRAFT; __ OTHER; __ NONE.

9. **MUSCULOSKELETAL (BONE AND MUSCLE RELATED):**
__ RHEUMOTOID ARTHRITIS; __ GOUT; __ OSTEOARTHRITIS; __ BROKEN BONES; __ SPINAL FRACTURES; __ SPINAL SURGERY'S; __ JOINT SURGERY; __ ARTHRITIS (UNKNOWN TYPE); __ SCOLIOSIS; __ METAL IMPLANTS; __ OTHER; __ NONE.

10. **PSYCHOLOGICAL:**
__ PSYCHIATRIC DIAGNOSIS; __ DEPRESSION; __ SUICIDAL IDEATIONS; __ BIPOLAR BEHAVIOR; __ HOMICIDAL IDEATIONS; __ SCHIZOPHRENIA; __ PSYCHIATRIC HOSPITALIZATIONS; __ OTHER; __ NONE.

- **IS THERE ANYTHING ELSE IN YOUR PAST MEDICAL HISTORY THAT YOU FEEL IS IMPORTANT TO YOUR CARE HERE?**

_____
_____
_____.

I certify that the information on these forms are true to the best of my knowledge, and hereby authorize this East Vancouver Chiropractic to provide me with Chiropractic, Massage, Acupuncture and/or therapeutic care for my condition.

Patient Signature: _____ Date: ____ / ____ / ____

AUTHORIZATION FOR THE RELEASE OF MEDICAL/CHIROPRACTIC RECORDS AND X-RAYS

I AUTHORIZE ANY DOCTOR, HOSPITAL, EMPLOYER, INSURER, OR OTHER PERSON, TO WHOM A SIGNED, ORIGINAL OR PHOTOCOPY OF THIS AUTHORIZATION IS DELIVERED, TO FURNISH ANY INFORMATION, REPORTS, OR COPIES OF RECORDS OR RADIOLOGICAL INFORMATION, WHICH MY BE REQUESTED TO
EAST VANCOUVER CHIROPRACTIC.

THIS AUTHORIZATION SHALL REMAIN VALID FOR ONE YEAR FROM THE DATE SIGNED.

_____ _____
SOCIAL SECURITY NUMBER **DATE OF BIRTH**

_____ _____
SIGNATURE **DATE SIGNED**

FINANCIAL POLICY FOR PERSONAL INJURY CLAIMS

This statement is to familiarize you with our financial policy in regards to your personal injury claim. Depending on the circumstances of your accident you may be eligible for insurance coverage for treatment of your injuries.

If you were injured in an auto accident, you may be entitled to medical coverage through your policy or the policy on the vehicle you were in. With this type of coverage the insurance should cover the costs of your treatment. If another party caused your injury, then your insurance company will be reimbursed for charges when you make the final settlement with the responsible party or their insurance company.

Should you not have insurance coverage this office this office may or may not agree to wait for payment until settlement of your claim with the responsible party. However, this decision will be made by our office on an individual basis depending on the circumstances of your case. If a lien under RCW 60.44.060 is required to be filed, I agree to be charged for that expense. We do not guarantee payment by the insurance companies nor is payment contingent on any settlement or verdict in your favor. You are ultimately responsible for payment of all charges at this office. A financial charge of 1.5% per month will be charged on all outstanding balances over 60 days.

CONSCENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of East Vancouver Chiropractic Clinic. I understand that diagnosis or treatment may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. This Clinic is not required to agree to the restrictions that I may request. However, if the Clinic agrees to a restriction that I request, the restriction is binding upon them. I have the right to revoke this consent, in writing, at any time, except to the extent that Clinic has already taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition that identifies me, or there is reasonable basis to believe the information may identify me. Prior to my signing this document, I understand I have a right to review this Clinics "Notice of Privacy Practices" which describes my rights, and the duties of this Clinic. With respect to my protected health information, types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of this Clinic. A copy of which is posted in the office and was provided to me. This Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

MISSED APPOINTMENTS: PLEASE BE COUTEOUS AND KEEP YOUR SCHEDULED APPOINTMENTS. THAT TIME HAS BEEN RESERVED FOR YOU. HOWEVER, SOMETIMES A PATIENT MAY REQUIRE EXTENSIVE CARE AND WE WILL APPRECIATE YOUR PATIENCE DURING THAT TIME. A 24-HOUR NOTICE FOR CHANGE OF APPOINTMENT WOULD BE MOST APPRECIATED.

_____ _____

PATIENT OR PATIENTS' REPRESENTATIVE SIGNATURE **DATE**