Automobile Accident Questionnaire

Accident Information

Name:_____Date:_____

1. Date of Accident: _____Time:_____ a.m./p.m.

2. Driver of car: _____Where you were seated:_____

3. Owner of car: _____Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: □ head-on collision □ broad-side collision □ rear-end collision

□ front impact, rear-ended car in front □ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? □ Yes □ No

11. Did you brace for impact? □ Yes □ No

12. Were you wearing a seatbelt? □ Yes □ No

13. Were you wearing a shoulder harness? □ Yes □ No

14. Does the car have headrests? □ Yes □ No

15. If yes, what was the position of your headrest? □ top of headrest even with bottom of head

□ top of headrest even with top of head □ top of headrest even with middle of head

16. Was your car braking? □ Yes □ No Was the other car braking? □ Yes □ No

17. Was your car moving at the time of the accident? □ Yes □ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact?

□ head turned left/right □ body straight in sitting position □ head looking back

□ body rotated left/right □ head straight forward □ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: □ rendered unconscious □ dazed □ other: _____

22. Could you move all parts of your body? □ yes □ no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? □ yes □ no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? □ yes □ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that □ day □ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

□ headache	□ loss of smell	□ numbness in fingers	□ neck pain/stiffness
□ loss of taste	□ cold hands	□ mid-back pain	□ loss of memory
□ cold feet	□ low-back pain	□ fatigue	□ diarrhea
□ tension	□ constipation	□ pain behind eyes	□ shortness of breath
□ chest pain	□ dizziness	□ irritability	□ nervousness
□ fainting	□ depression	□ cold sweats	□ anxious
□ sleeping problems	□ loss of balance	□ numbness in toes	
□ ringing/buzzing in ears		□ eyes sensitive to light	□ other:_____

27. Have you missed time from work? □ yes □ no Work hours are: □ full-time □ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? □ yes □ no

29. Did you seek medical help immediately/soon after the accident? □ yes □ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? □ yes □ no If yes, of what body part? _____

32. What treatments/prescriptions were given? □ bed rest □ brace □ adjustments □ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

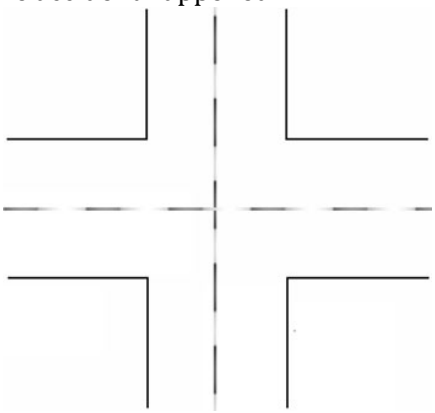
35. Are any of your activities of daily living any different now compared to before the accident?
□ yes □ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

_____

_____

_____

_____

37. Do you have an attorney handling this case? □ yes □ no

If yes, who? (name/address)_____

_____

Insurance Information

Patient's personal insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____ Adjuster's name/phone: _____

_____

Other party's insurance: _____

Insured's name (if other than patient) _____ Policy #: _____

Insurance Company Name: _____ Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____ Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____

Adjuster's name/phone: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Dr. Sharon Bruce** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **Dr. Sharon Bruce** the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay **Dr. Sharon Bruce** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____

Patient's Demographic Information

Patient's full name:: _____

Address: _____

Date of Birth: _____

Email: _____

Mailing address (if different): _____

Phone: _____ Email: _____

Employer name: _____

Spouse's Occupation: _____

Employer's address: _____

Work phone: _____

Spouse's name: _____

Spouse's employer: _____

Occupation: _____

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? ☐ Yes ☐ No Hours per week _____What activity(s)? _____

_____

Are you dieting? ☐ Yes ☐ No Since:_____ Do you smoke? ☐ Yes ☐ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? ☐ Yes ☐ No ____drinks per day.

Do you wear? ☐ Heal lifts ☐ Arch supports ☐ Prescription Orthotics

For women: Are you pregnant or nursing? ☐ Yes ☐ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

What makes your system worse? _____

What makes your system better? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

Have you experienced these symptoms in the past?_____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

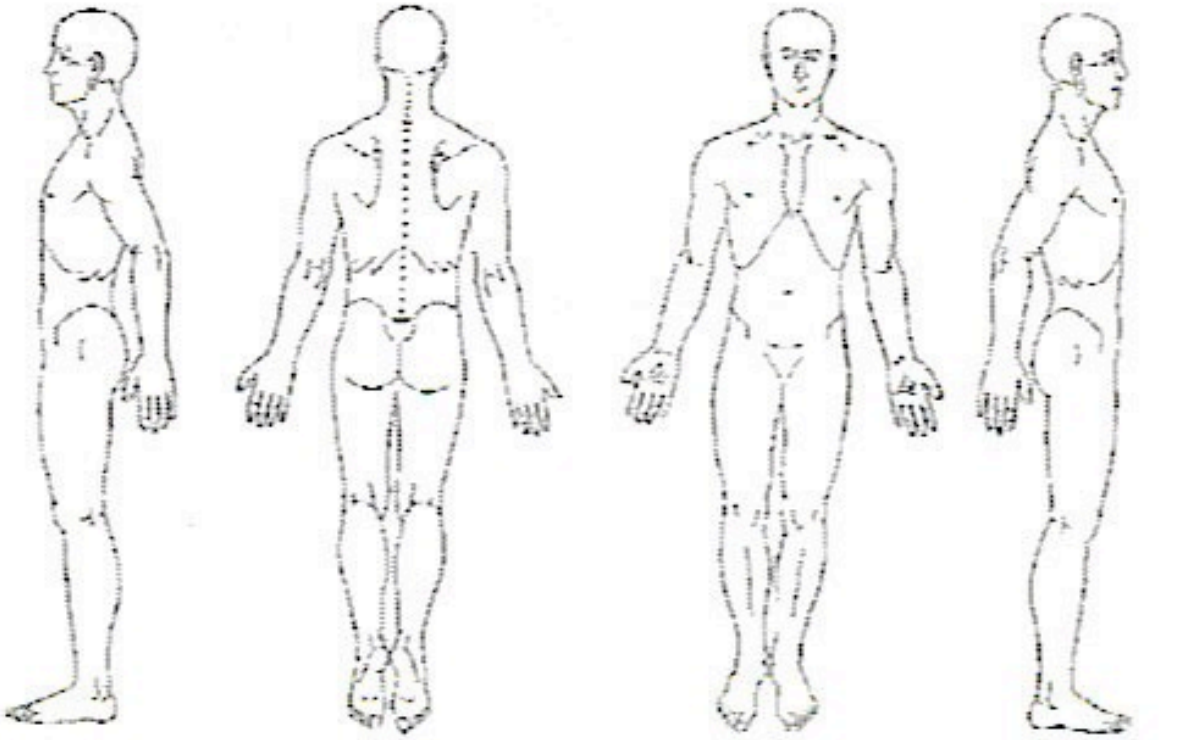
Have you seen a chiropractor before? ____Yes ____ No **Who referred you to us?** _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Excessive thirst	○	○	Mid back pain
○	○	Abnormal Weight gain/loss	○	○	Frequent Urination	○	○	Migraines
○	○	Allergies	○	○	General Fatigue	○	○	Neck pain
○	○	Angina	○	○	Hand pain	○	○	Painful Urination
○	○	Ankle/foot pain	○	○	Headaches	○	○	Prostate Problems
○	○	Arthritis	○	○	Heart attack	○	○	Shoulder pain
○	○	Asthma	○	○	Hepatitis pressure	○	○	Smoking/tobacco Use
○	○	Bladder Infection	○	○	High blood pressure	○	○	Stroke
○	○	Birth Control Pills	○	○	Hip/upper leg pain	○	○	Systematic Lupus
○	○	Cancer	○	○	HIV/AIDS	○	○	Thoracic Outlet Syndrome
○	○	Chest Pains	○	○	Hormone Therapy	○	○	Tumor
○	○	Chronic Sinusitis	○	○	Jaw pain	○	○	Ulcer
○	○	Depression	○	○	Joint swelling/stiffness	○	○	Upper back pain
○	○	Dermatitis/Eczema	○	○	Kidney Stones	○	○	Wrist pain
○	○	Dizziness	○	○	Knee/lower leg pain			
○	○	Drug/Alcohol Use	○	○	Liver/Gall Bladder Disorder			
○	○	Elbow/upper arm pain	○	○	Loss of Bladder Control			
○	○	Epilepsy	○	○	Low back pain			

Additional comments you would like the doctor to know: _____

_____

Patient's signature: _____

Doctor's signature: _____

Financial Policy

Insurance Coverage

Welcome to **The Lumbar Yard.** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Missed Appointments

It is the policy of **The Lumbar Yard** to assess a **$10** missed chiropractic visit fee and a **$45** missed massage visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

NATURE OF THE CHIROPRACTIC ADJUSTMENT. The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

ANALYSIS, EXAMINATION, AND TREATMENT. As a part of the analysis, examination, and treatment, you are consenting to the following procedures (please initial):

_____ Spinal Manipulative Therapy
_____ Palpation
_____ Vital Signs
_____ Range of Motion Testing
_____ Orthopedic Testing
_____ Basic Neurological
_____ Muscle Strength Testing
_____ Postural Analysis Testing
_____ Ultrasound
_____ Hot/Cold Therapy
_____ Electrical Muscle Stimulation
_____ Radiographic Studies
_____ Other: _____
_____ **All of the above**

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT. As with any healthcare procedure, there are certain complications which may arise during spinal manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

PROBABILITY OF THOSE RISKS OCCURRING. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS. Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization; and/or surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with **Dr. Sharon Bruce** and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient's signature (Guardian if a minor) Date

_____ _____
Doctor's Signature Date

_____ _____
Patient's Printed name

_____
Doctor's Printed Name

Sharon D. Bruce, DC, DACBSP
The Lumbar Yard

Acknowledgement of Receipt of
Notice of Privacy Practices

This form will be retained in your medical record

NOTICE TO PATIENT

We required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ **Date of Birth:** _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **The Lumbar Yard**.

I understand that the Notice describes the uses and disclosures of my protected health information by **The Lumbar Yard** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ Communications barriers prohibited obtaining the acknowledgement

☐ Other (please specify) _____

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

A variety of procedures and modalities are utilized by doctors of chiropractic for treatment of whiplash injuries. The physiological effects and benefits of these therapies are outlined below. It should be noted that the use of some of these therapies often make it possible for the doctor of chiropractic to provide a more gentle adjustment than would be required without such care. Additionally, by ameliorating the soft tissue problems, the use of these therapies may help better maintain the inter-osseous correction. The summaries below are highly abbreviated and not intended to be a complete delineation of their therapeutic usefulness.

Therapy	CPT	Therapeutic/Physiologic Benefits	Comments
1. Cold Pack (Cryotherapy)	97010	Cold is typically used in the acute phase of an injury and for flare-ups. Its use reduces inflammation and sedates the treated area. It is typically used for the first 3-7 days post-injury and for a few days if a flare-up develops.	Since the cost of the cold pack is low and be self-applied, repeated billing for this service is often questioned.
2. Hot Pack (thermal therapy)	97010	Heat is typically used after the inflammatory phase to reduce spasm, decrease pain and restore mobility.	Since the cost of the hot pack is low and can be self applied, repeated billing for this service is often questioned.
3. Electrical Muscle Stimulation	97014	Electrical muscle stimulation includes a variety of modalities that can, depending on the type and frequency of wave form, reduce pain, inflammation and/or spasm. Some forms of muscle stimulation can also retrain and strengthen muscles.	While this form of therapy works well on larger body regions, it may be difficult effectively apply to smaller muscle areas.
4. Diathermy	97024	Diathermy is a means of deeply heating tissues using a specialized electromagnetic wave generating machine. It relaxes muscles, sedates the treated region and stimulates the blood flow of the region.	Contraindications to the use of this device include: use over a gravid uterus, metal implants and the brain.
5. Iontophoresis	97033	Iontophoresis electronically forces ionic forms of various therapeutic substance through the skin into tissues as a means of reducing edema, calcific areas, scar tissue, etc.	Care must be taken not to burn or cause other significant irritation to the skin when using this therapy.
6. Mechanical Traction	97012	Intermittent mechanical traction opens up joint spaces, thereby reducing pressure on nerves, facets and other compressed tissues. It also can reduce spasms and adhesions.	A highly useful form of therapy throughout all phases of whiplash care on many patients.
7. Massage	97124	Besides being relaxing, therapeutic massage is effective in reducing spasm and other muscle conditions, thereby reducing pain and increasing range of motion. The skill of the practitioner plays a significant role in the effectiveness of the treatment.	Massage is occasionally overused in PI cases. Its use should be confined to the injured regions and used only for reasonable periods of time.
8. Cold Laser Therapy (Low Level Laser)		A form of therapy that utilizes specific wavelengths of light to interact with tissues and is thought to help accelerate the healing process. It can be used on patients who suffer from a variety of acute and chronic conditions in order to help eliminate pain, swelling, reduce spasm and increase functionality.	While studies vary on its effectiveness, there is growing support for this therapy among doctors and patients.
9. Myofascial Release	97140	This is a more aggressive form of manual therapy designed to treat certain muscle problems, including trigger points and adhesions.	When used appropriately, this therapy can reduce the chronicity of certain post-traumatic conditions.
10. Extracorporeal Shock Wave (ESWT)	25890	A form of treatment using directed shock waves that cause physical changes in the tissue. Reports indicate that such tissue changes can cause long-lasting, increased function and decreased pain in select conditions.	ESWT offers a noninvasive option for certain conditions that are often highly resistant to most other treatments.
11. Neuromuscular Reeducation	97112	This therapy involves the retraining of movement, balance, coordination, kinesthetic-sense, posture and propriaptive neuromuscular facilitation.	The re-establishment of neural pathways and/or neurological "loops" can have long-term benefits to significantly injured regions.
12. Therapeutic Exercise	97110	Therapeutic exercise	Proprioceptive therapeutic exercise to develop strength & endurance, range of motion & flexibility.
13. Ultrasound	97035	Ultrasound uses a very high frequency sound wave to dispense swelling and waste products from an injured region. It can penetrate deeply into tissues and has sedative effects as a result of heat generation from molecular friction.	Ultrasound can be used in any phase of the healing process but has a number of contraindications for its use.
14. Spinal Manipulation	98940-09843	This form of treatment has considerable evidence supporting its effectiveness in restoring function and decreasing pain, both short and long term. Its primary goal is to restore proper spinal function.	A doctor of chiropractic is almost always the best-trained person to administer this form of therapy.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information: O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax: P=Phone: E=Email: M=Mail: O=Other

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