

# 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 since the accident:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> headache                | <input type="checkbox"/> loss of smell   | <input type="checkbox"/> numbness in fingers     | <input type="checkbox"/> neck pain/stiffness |
| <input type="checkbox"/> loss of taste           | <input type="checkbox"/> cold hands      | <input type="checkbox"/> mid-back pain           | <input type="checkbox"/> loss of memory      |
| <input type="checkbox"/> cold feet               | <input type="checkbox"/> low-back pain   | <input type="checkbox"/> fatigue                 | <input type="checkbox"/> diarrhea            |
| <input type="checkbox"/> tension                 | <input type="checkbox"/> constipation    | <input type="checkbox"/> pain behind eyes        | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> chest pain              | <input type="checkbox"/> dizziness       | <input type="checkbox"/> irritability            | <input type="checkbox"/> nervousness         |
| <input type="checkbox"/> fainting                | <input type="checkbox"/> depression      | <input type="checkbox"/> cold sweats             | <input type="checkbox"/> anxious             |
| <input type="checkbox"/> sleeping problems       | <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes        |  |
| <input type="checkbox"/> ringing/buzzing in ears |  | <input type="checkbox"/> eyes sensitive to light | <input type="checkbox"/> 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: \_\_\_\_\_

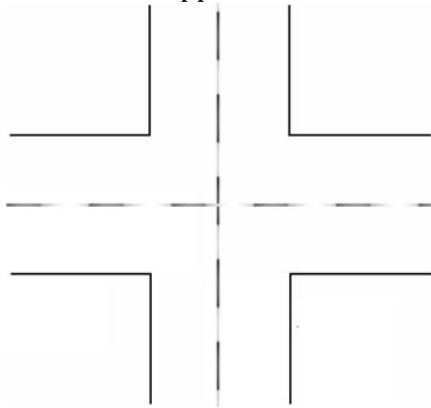
35. Are any of your activities of daily living any different now compared to before the accident?  
 yes  no

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:

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

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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):

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Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

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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?  Heel 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.

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Are you here because of an accident? \_\_\_\_\_ What type? \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_ How did your symptoms begin? \_\_\_\_\_

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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? \_\_\_\_\_

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Have you experienced these symptoms in the past? \_\_\_\_\_

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## 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: \_\_\_\_\_

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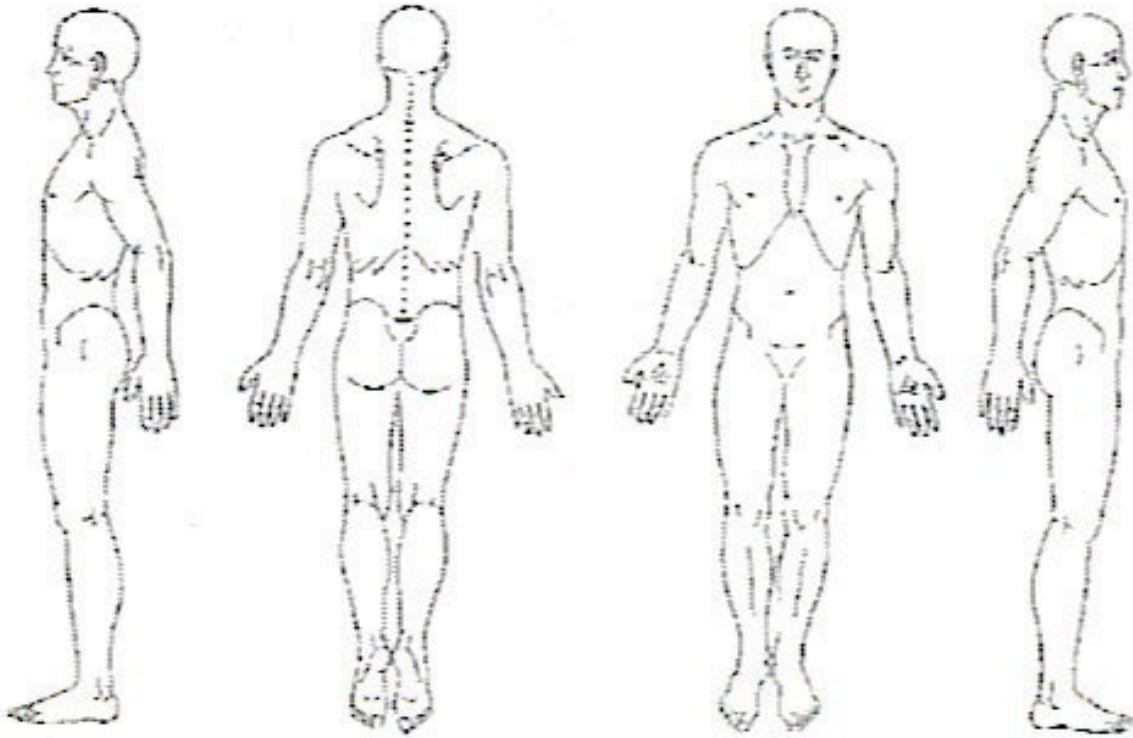
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## Description of Condition

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 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ 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
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Migraines
<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Hepatitis pressure	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Wrist pain
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain			
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder			
<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control			
<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	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



**Acknowledgement of Receipt of  
Notice of Privacy Practices**

*This form will be retained in your medical record*

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***NOTICE TO PATIENT***

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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*

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***FOR OFFICE USE ONLY***

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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 Reduction	97112	This therapy involves the retraining of movement, balance, coordination, kinesthetic-sense, posture and proprioceptive 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 disperse 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.

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## 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):**

- |  |   |
|--|---|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number<br><br><input type="checkbox"/> Other _____<br>_____ |
|--|---|

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

