Name:
DOB:

ADKINS CHIROPRACTIC PC

Auto Injury History Form

Please fill out completely & initial the bottom of each page. The questions on these forms will help us to diagnose you problem and better assist you in your claim.

General Information:

Date of Injury:_____

Approximate time of Injury:_____

Accident History Prior to Crash:

Any previous pain/problems in area injured? (Please answer. If so, explain.)_____

_____

_____

Was the accident on the job? ☐ Yes ☐ No

You were: ☐ Driver ☐ Front seat passenger
☐ Rear seat passenger ☐ Other:_____

Vehicle driven by:_____

Your vehicle (year, make, model):_____

Your estimated speed at moment of accident:_____

☐ Stopped ☐ Slowing ☐ Accelerating

Other vehicle (year, make, model):_____

Other vehicle estimated speed at moment of accident:_____

Road Conditions: ☐ Dry ☐ Damp ☐ Wet
☐ Snow ☐ Ice ☐ Other:_____

Please indicate location of head restraint at the time of the accident:

☐ At the top of the back of my neck ☐ At the middle of the back of my head
☐ At the bottom of the back of my head ☐ At the back of my neck
☐ Below my neck at shoulders ☐ No head restraint
☐ Head restraint/seat are attached (Integral type)

If adjustable, was the position altered by the accident? ☐ Yes ☐ No

Was it pushed down? ☐ Yes ☐ No

Was the seat back adjustment altered by the accident? ☐ Yes ☐ No

Did the seat move forward or backwards? ☐ Yes ☐ No

Do you have your seat reclined when you drive?

☐ A little ☐ Some ☐ A lot

Was the seat broken? ☐ Yes ☐ No

Was your seatbelt broken? ☐ Yes ☐ No

Lap belt/Shoulder belt: ☐ Wearing ☐ Not Wearing

Were you aware of the impending crash? ☐ Yes ☐ No

Did your air bag deploy? ☐ Yes ☐ No

If yes, were you struck? ☐ Yes ☐ No

Body position: ☐ Straight ☐ Forward lean ☐ Other_____

Head position: Which way were you looking upon impact?

☐ Straight forward ☐ Up ☐ Down
☐ Left ☐ Right

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A

Brakes applied? ☐ Yes ☐ No

Brief accident description:

_____

_____

_____

_____

Please Turn Over

Name:
DOB:

Accident Diagram: Please describe street names & direction you were heading. Draw an "x" where each vehicle sustained the most damage. A square represents your car (#1) and an oval represents the other car (#2). Use arrows to show your direction.

Accident History

Did you strike any parts of the vehicle? ☐ Yes ☐ No
If yes, describe:
_____
_____
_____

Did your vehicle strike any objects after crash? ☐ Yes ☐ No
If yes, describe:
_____
_____
_____

Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long?_____

Accident History <u>After the Crash</u>:

Your Insurance Company:_____ Claim #:_____
At Fault Drivers Insurance Company:_____ Phone #:_____
At Fault Drivers Name:_____
Were the police on-scene? ☐ Yes ☐ No
If yes, was a report made? ☐ Yes ☐ No
Symptoms: ☐ Head ache ☐ Dizziness
☐ Nausea ☐ Confusion/disorientation
☐ Neck pain ☐ Back pain
☐ Arm/leg pain ☐ Other:_____
Please describe when you noticed each symptom after the crash.
_____
_____

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Where did you go after accident? ☐ Home ☐ Work ☐ Hospital
☐ Other:_____
Mode of transportation:_____
Private Doctor:_____
If you have not seen a doctor for this injury within the first month after accident, please indicate reason(s):

- ☐ Did not notice any pain
- ☐ Time Conflict
- ☐ Unable to schedule appointment
- ☐ No Transportation
- ☐ I thought the pain would disappear
- ☐ I had no insurance money
- ☐ I self treated with over-the-counter drugs
- ☐ Took hot showers, used ice/heat
- ☐ Other:_____

Have you been unable to work since the accident? ☐ Yes ☐ No
If yes, were you off work (please list dates):_____

Confidential Auto Case History

Please fill in this questionnaire COMPLETELY. If a section does not apply to you, simply cross it out. This confidential history will be a part of your permanent records.

What are your major complaints in order of intensity? (#1 most bothersome)
1)_____2)_____3)_____4)_____
Please place an x on the lines below and write the area of pain in each below and the frequency of your pain.
Sample Only:
0----------x----------x----------x----------10
No Pain Neck Left Leg Low Back Extreme Pain
Constant Frequent Intermittent/Occasional
Indicate the severity of your symptoms. (10 is the worst possible pain that can be felt)
How bad are your symptoms now?

0----------10
No Pain Extreme Pain

How bad are your symptoms most of the time?

0----------10
No Pain Extreme Pain

How bad have they been in the past?

0----------10

No Pain Extreme Pain

When during the day are your symptoms: (Ex: Morning, Evening)
Worse_____
Better_____
Please rank in order of intensity which movements/positions make each area worse:
(Sample: 1. Neck –reading, turning head; 2. Low back – sitting, walking)
1._____

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2._____
4._____
Please describe which movements/positions make each area better: (Sample: Neck – exercises)
_____
_____

Functional Information

Has pain interfered with your social life, hobbies, or sexual ability?
☐Yes ☐ No If so, how?_____
How many hours a night do you sleep since the injury?_____
Before your pain/injury?_____
Do you know why?_____
Does pain frequently awake you? ☐Yes ☐No
If yes, about how many times would you wake up per night?_____
Before your pain how many times would you wake up per night?_____
Sleep position: ☐Back ☐Stomach ☐Right side ☐ Left side
At any one time, how many hours can you:
Sit____hrs. Walk____hrs. Stand____hrs. Bend____hrs.
Is this condition interfering with: (Please circle) work, sleep or other daily routines such as reading, housecleaning, driving, sitting, dressing, etc.? Discuss what areas of your body you have more problems with due to each activity.
_____
_____

Past Injury History

Have you had any prior on-the-job injuries? ☐Yes ☐No
Have you had any automobile accident injuries? ☐Yes ☐No
If disabled, (as worker/student/homemaker), date last worked?_____
If disabled, have you tried to return to work? ☐Yes ☐No
What day?_____ ☐Part Time ☐Full Time
Have you received disability income related to this condition?
☐ Yes, receive now ☐ Yes, in the past ☐ No, never
Is this a work related or auto accident injury?
☐ Auto Accident ☐ Work Accident ☐ Neither

Social History

Work Status: ☐Full Time ☐ Part Time ☐Student ☐ Disabled ☐ Unemployed ☐Retired
In a typical workday, your job requires that you: (8hrs total)
Sit____hrs. Walk____hrs. Stand____hrs. Bend____hrs.
Physical Work: ☐Heavy ☐Moderate ☐Light Hours/day:_____
Number of children:_____ Ages:_____
What are your hobbies / organizations in which you participate? (To determine if your extracurricular activities could be making your condition worse)
1)_____ 2)_____
3)_____ 4)_____
Exercise: ☐Heavy ☐ Moderate ☐Light Hours/day:_____
Type:_____
Have you recently lost or gained weight? ☐Yes ☐No If so how much?_____
Writing Hand: (Please circle) Left Right Ambidextrous

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Results of Treatment

What are the results you hope for:

	Pain reduction
	Increased recreation
	Improved emotional well-being
	Return to work
	Elimination of drugs
	Better daily function
	Other:_____

What do you hope will be the results of this evaluation:

	Medical Diagnosis
	Recommendation for rehabilitation
	Recommendation for surgery
	Recommendation for treatment
	Determine the existence of a disability
	Other:_____

Release of Information:

The physician may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician or the patient or to a family member or employer of the patient for all part or part of the physician charges, including but not limited to, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

As a courtesy, we may send your primary care physician reports about your treatment with our office. By signing below I authorize my records to be sent to my primary care physician and the release of any medical or other information necessary to process my claims. Our office will photograph you on your first visit for identification purposes. Your photograph may be sent to your insurance company with your medical records. Any other use will require your consent.

Consent for Treatment:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.

I understand that rehabilitation medicine occasionally aggravates an existing condition and that this may be possible in respect to my condition. I understand treatments rendered by Adkins Chiropractic P.C. are intended to aid in the reduction of my pain and to allow as full a recovery as possible and are not intended to aggravate an existing condition or cause a new one to occur.

I have carefully completed and reviewed this form to the best of my knowledge.

_____ _____

Signature Date

_____

Relationship to patient (if not self)

Please Turn Over

Name:
DOB:

FINANCIAL AGREEMENT
ACCIDENT AND PERSONAL INJURY

Thank you for choosing us for your healthcare needs. Our ultimate goal is to return you to pre-injury status as soon as possible. The doctor will determine your treatment plan; it is very important to follow your recommended treatment schedule for ultimate improvement. If unable to make a scheduled appointment, please call to reschedule.

If you have been involved in a motor vehicle accident, it is important that you report the accident to your insurance agent and request a claim number and the appropriate billing information. Please provide a copy of the accident report if applicable.

As a courtesy Adkins Chiropractic will be glad to bill your med-pay portion to your insurance company as long as we have your current information on file, and you provide us with a copy of your insurance claim number.

If you have a third party claim, payment will be directly billed to you. Most health insurance companies will pay if an agreement is signed to reimburse them after settlement is made. You will be responsible for any co-pays and service charges.

Insurance billing is submitted weekly. Your initial report will be billed within three days after your visit. To process insurance claims quicker, please call your insurance carrier to answer any questionnaires.

Even though an insurance claim has been filed, you will receive a statement each month if your account has a balance due.

If a balance goes over $2,000.00, a lien will be filed.

This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Patients should remember that professional services are rendered and charged to the patient and not to the insurance company.

*Supplies and supplements to be paid for a time of visit.

Service Charge: If fees for services rendered are not paid within 90 days from the date of service, a finance charge of 0.875% APR per month on the unpaid balance will be assessed.

As our main focus is to return you to pre-injury status, if for some reason your claim is denied, we expect you to follow through with the paperwork for appeals. We will assist you with any forms.

_____ _____

Signature Date

Please Turn Over