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MOTOR VEHICLE ACCIDENT INFORMATION

PATIENT NAME: ______________________________ DATE: ______________

ADDRESS: ______________ CITY: ______________ STATE: ________ ZIP CODE: __________

DATE OF BIRTH: ______________ SOC. SEC. #: ______________ HOME/CELL PHONE: ______________

ACCIDENT HISTORY:

DATE OF ACCIDENT: ______________ TIME OF ACCIDENT: ______________ ____AM ____PM

PLEASE DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: ______________________________

Were you the: ___Driver ___Front Passenger ___Rear Passenger ___Pedestrian How many people were in vehicle? ______
Accident Site: Street/Road/Intersection: ______________ City: ______________ State: ________
Direction you were headed? ______________ Speed you were traveling? ______________ Your vehicle type? ______________
How was your vehicle struck? ____ Front ____ Back ____Right Side ____Left Side Comments: ______________

Did your vehicle impact another vehicle? _____Yes _____No _____Front _____Back _____Right Side _____Left Side
Other type of vehicle involved? ______________ Direction headed? ______________ Speed? ________
Driving conditions: ___Dry ___Wet ___Icy ___Other Were you wearing a seat belt? ________ Air bags deployed? ________
At the time of impact were you? _____Looking straight ahead _____Looking to the left/right _____Looking up/down
Did any part of your body strike anything in the vehicle? ____Yes ____No If yes, please explain: ______________

At the time of impact were you: _____Suprised by the impact _____Braced for impact
Both hands on steering wheel? _____Yes _____No ______Right Hand _____Left Hand
Which foot was on the brake, if any? _____Right _____Left ______Both
Did you vehicle impact a structure? ________ Describe: ______________________________
Police/Aid Vehicle come to the scene? _____Yes _____No If yes, please describe: ______________

Was there a police report filed? ___Yes ___No Was a traffic violation issued? ___Yes ___No If yes to whom? ________

INSURANCE INFORMATION:

Policy Holder's Name: ______________________________ Date of Birth: ______________
Insurance Company: ______________________________ Phone Number: ______________
Policy/ID Number: ______________________________
Adjuster's Name: ______________________________ Claim Number: ______________

INTER-OFFICE USE ONLY

VERIFIED BILLING ADDRESS: ______________ VERIFIED PIP IS OPEN AND AVAILABLE: ______________

SPOKE TO: ______________ DATE: ______________ TIME: ______________ INITIAL: ______

Patient Name: ____________________

PATIENT CONDITION:

Please describe how you felt:

During the accident: ____________________

____

Immediately after the accident: ____________________

____

Later that day: ____________________

____

The next day/days: ____________________

____

Did you go to the hospital or another medical facility? ____Yes ____No If yes, when and where? ____________________
Address: ____________________
Doctor's Name: ____________________ Treatment received: ____________________
Test procedures provided: ____________________ Diagnosis: ____________________

SYMPTOMS / INJURIES:
If you have had any of the following since your injury, please check.

___Neck Pain	___Dizziness	___Ear Ringing
___Neck Stiffness	___Headaches	___Jaw Problems
___Arm/Shoulder Pain	___Irritability	___Sleep Difficulty
___Mid Back Pain	___Fatigue	___Blurred Vision
___Mid Back Stiffness	___Elbow Pain	___Nausea
___Chest Pain	___Wrist/Hand Pain	___Memory Loss
___Low Back Pain	___Knee Pain	___Tension
___Low Back Stiffness	___Ankle/Foot Pain	___Stomach Upset
___Leg Pain	___Other ____________	

Please mark with an "X" the location of pain/discomfort

What is your number – one problem or the one area of greatest pain/discomfort? ____________________
Please rate the level of this pain on the following scare: 0 is no pain, 10 is severe pain. If your pain varies from day to day, please indicate a range of your pain. ____________________

Please describe other area of pain and discomfort, please rate on a scale of 0 to 10.

1. ____________________
2. ____________________
3. ____________________

Since the accident, is your pain? ____Getting worse ____Staying the same ____Improving
Does it interfere with your? ____Daily Routine ____Work ____Sleep ____Recreation
Movements that are painful to perform: ____________________
What increases your pain? ____________________
What decreases your pain? ____________________
Please add anything else you would like the doctor to know: ____________________

____

____

____

Patient Signature: ____________________ Date: ____________________
(patient, parent, guardian)

HEALTH HISTORY:

Are you taking any of the following medications?

☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Blood Pressure Medications ☐ Tranquilizers ☐ Insulin ☐ Stimulants

List the names of medications/supplements you are currently taking:

____

____

____

Please circle any condition you have or have had in the past:

Y N Severe or frequent headaches	Y N Diabetes	Y N Kidney Problems	Y N HIV/Aids
Y N Frequent neck pain	Y N Digestive problems	Y N Tuberculosis Y N Anemia	Y N Asthma
Y N Pain between the shoulders	Y N Loss of Sleep Y N Alcohol / drug issues		Y N Low back pain
Y N Numbness or pain in arm / legs / hands	Y N Psychiatric problems	Y N Rheumatic fever	Y N Heart attack
Y N Seizures / Epilepsy	Y N mphysema	Y N Cancer	Y N Hepatitis
Y N Difficulty breathing	Y N Chemotherapy	Y N Glaucoma	Y N Arthritis
Y N Artificial bones / joints / implants	Y N High / low blood pressure	Y N Congenital heart defect	Y N Ulcers / colitis
Y N Thyroid problems	Y N Sinus problems	Y N Heart murmur	Y N Dizziness
Y N Stroke	Y N Other____________		

Do you have any allergies? If yes, please explain:

____

____

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

____

____

____

List any past serious accidents with dates:

____

Do you exercise? ☐ Yes ☐ No ______ hours per week Do you drink coffee? ☐ Yes ☐ No ______ cups per day

Do you smoke? ☐ Yes ☐ No ______ how many per day For how long __________

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting: ☐ Yes ☐ No If yes, since

____

For Women: Are you taking birth control? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No If yes, how many weeks?

_____

Do you experience painful periods? ☐ Yes ☐ No Irregular cycles? ☐ Yes ☐ No Breast feeding?? ☐ Yes ☐ No

AUTHORIZATION FOR CARE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my dependent ever has a change in health.

I hereby authorize the Doctor and appointed staff to work with my condition through the use of chiropractic care, rehabilitation, nutrition and other modalities agreed upon as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand payment in full for all services rendered is required in full at the time of service unless other arrangements have been made in advance. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I authorize the provider to release any information required to process insurance claims. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

______________________	______________________	__________
Signature of Patient, Parent, Guardian	Print name of Patient, Parent, Guardian	Date

Patient Name:

What is your current problem and when did it begin? Also, on a scale from 0-10, 10 being the worst please circle the number that best describes the symptom most of the time.

1.________________________________ 0 1 2 3 4 5 6 7 8 9 10

2.________________________________ 0 1 2 3 4 5 6 7 8 9 10

3.________________________________ 0 1 2 3 4 5 6 7 8 9 10

4.________________________________ 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptoms?

1.________________ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

2.________________ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.________________ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4.________________ 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

What makes the symptom worse? (Circle all that apply): Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):________________________________

What makes the symptom better? (Circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):________________________

Describe the quality of the symptom (Circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging other (please describe): ________________________

Does the symptom radiate to another part of your body? (Circle one): YES NO

If yes, where does the symptom radiate?________________________________

Is the symptom worse at certain times of the day or night? (Circle one): Morning Afternoon Evening Night Unaffected by the time of day

Have you had to modify your lifestyle in any way due to these symptoms? (Circle one): YES NO

If yes, please describe:________________________________

Patients Signature: ________________________________

STAFF ONLY: ____________ BP ______ Pulse ______ L ______ R – Weight Scales ______ Height

______ L ______ R – Grip Strength Any NEW Allergies? Y N What?________________

Any NEW Surgeries? Y N What?________________ When? ________________

Any NEW Medications? Y N What? ________________________________

Exercise? Y N daily weekly What type? ________________ Caffiene? Y N ________________________

____ (Signature of Staff)

Plateau Chiropractic & Massage

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Sammamish, WA 98074

425-868-9593

Account No.:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have been provided a readable copy of the Notice of Privacy Practices (HIPPA):

- It tells me how Plateau Chiropractic & Massage will use my health information for the purposes of my treatment, payment for my treatment and health care operations.
- The Notice explains in more detail how Plateau Chiropractic & Massage may use and share my health information for other than treatment, payment and health care operations.
- Plateau Chiropractic & Massage will also use and share my health information as required/permitted by law.
- It tells me that I can go to www.plateauchiropractic.com to print out a copy or I can request it to be e-mailed to me or I can request a paper copy of the Notice of Privacy Practices.

Patient's Complete Legal Name: ______________________________

Patient's DOB: Date: ____________________

Signature: ____

(Patient or legal representative*)

*May be requested to show proof of representative status