

Auto Collision Patient History

Date _____ cell# _____ Home# _____ E-mail _____

First Name _____ Middle _____ Last _____

Street Address _____ City _____ Zip Code _____

Male Female Date of Birth ____/____/____ Age _____ Married Single

Number of children _____ Are you currently pregnant? No Yes _____ months Are you nursing? No Yes

Collision Information

Date of Collision ____/____/____ Time _____ AM/PM City _____ State _____

Which were you? The Driver

The Passenger: Front seat Back seat: Behind driver Middle seat Behind front passenger

Or were you a Pedestrian?

Were you: Aware or Unaware of the collision prior to impact?

What direction was your head facing at impact? Straight Ahead Turned to the Left Turned to the Right

Other, Please Explain: _____

Were you wearing a Seatbelt with a shoulder harness or Lap belt only? No Seatbelt?

Describe where the headrest was in relation to the top of your head: Above Below Don't know

Did the airbag deploy? No Yes Road conditions were: Dry Wet Icy Snowy Unsure

Did the police come to the collision scene? No Yes

Where was the impact on your car? Front of car: Center Left Front Right Front

Rear end of car: Center Left Rear Right Rear

Side of car: T-boned Side-swipe Front half of car Back half of car

Describe how the accident occurred: _____

Did you hit any body parts on the inside of the vehicle? No Yes, Where? _____

Did you have any visible cuts or bruises? No Yes, Where? _____

Did you lose consciousness? No Yes, How long? _____

How soon after the accident did your pain begin? _____

Is this accident job related? No Yes, Have you reported it, and when? _____

Has an on-the-job injury claim been filed? No Yes, Claim # _____

Employer at time of injury: _____ Phone Number: _____

Name _____ Date: ____/____/____

Information about the Vehicle You Were In

Year _____ Make _____ Model _____

Approximate property damage to your vehicle, if known \$ _____

Information about the Other Vehicle

Year _____ Make _____ Model _____

If more than one other vehicle was involved please explain _____

Treatment Information

Did you go to the emergency room/ hospital? No Yes, When? _____

How did you get there? _____ Name of Hospital _____

Were X-rays/ MRIs/ CT scans taken? No Yes, Of what body parts? _____

Treatment: Admitted Exam and Discharge Neck collar Ice/Heat Medical Aids (crutches, etc.)

Medications (Please list) _____

Follow up instructions/ referrals: _____

Please list **other health care providers** you have seen for the condition(s), and **treatment** received.

Name & Location of Primary Care Physician (your family doctor): _____

Since the collision have you been experiencing:

Dizziness Balance problems Nausea Vomiting Confusion/ Disorientation Seizures

Headache Memory problems Loss of consciousness, # of episodes # of minutes _____

Today's Major Complaints

Please check ✓

Please **Circle** Your Level of Pain.

Area of Pain and Type of Pain

0= No Pain through 10=Extreme Pain

<input type="checkbox"/> Headache	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Lt	<input type="checkbox"/> Rt	<input type="checkbox"/> Ache	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Other _____							0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Other _____							0	1	2	3	4	5	6	7	8	9	10

Name _____ Date: ____/____/____

Health History

Cardiovascular/ Pulmonary/Respiratory:

- Heart/vascular conditions History of stroke Low blood pressure High blood pressure Difficulty breathing
- Lingered cough Asthma Chest congestion Chest pain Bronchitis
- Pneumonia Allergies Swollen ankles Frequent colds Sinus problems

Gastrointestinal:

- Heartburn Diarrhea Ulcers Stomach problems Liver problems
- Vomiting of blood Irritated colon/bowel Gallbladder problems Constipation Hemorrhoids

Urinary/Reproductive:

- Bladder problems Kidney problems Prostate trouble Menstrual problems

General/Other:

- Fatigue Poor Sleep Difficulty swallowing Diabetes Thyroid problems History of cancer

Any other problems not listed: _____

Current Height _____ **Current Weight** _____

What have you been doing at home to make your symptoms feel better? _____

Please indicate any medications or drugs you are taking:

- Anti-depressive medication Stimulants Insulin Tranquilizers Cholesterol medicine
- Pain killers (prescribed/OTC) Muscle relaxers Blood pressure medication Blood Thinners

Others: _____

Please list any prior falls, accidents, or other traumatic injuries:

Month/ Year	Type of Accident	Please describe accident/injury
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any prior fractures, surgeries or serious illnesses:

Month/ Year	Type of Illness	Please describe
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any serious diseases suffered by members of your immediate family (ex: cancer, heart disease, diabetes)

Name _____ Date: ____/____/____

Work/ Social History

What is your occupation? _____

Employer _____ Work Phone _____

Employer's Address _____

Have you lost time from work as a result of this injury? No Yes, Dates _____

Are you being compensated for time lost? No Yes Return to work date _____

Are you working: Full time Part time Regular duty Restricted duty

Explain any restrictions: _____

I feel more pain when doing the following activities:

Check the activities that cause pain and then **Circle** minimal, mild, moderate or severe.

<input type="checkbox"/> Sleeping	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Sitting	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Walking	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Standing	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Lifting	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Household Chores	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Routine Personal Care	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Child Care	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Sports/ Exercise	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Yard Work	Minimal	Mild	Moderate	Severe
<input type="checkbox"/> Other	Minimal	Mild	Moderate	Severe

Do you drink alcohol? No Yes, ____ Drinks Daily Weekly Monthly

Do you smoke? No Yes, ____ Packs Daily Weekly Monthly

Do you exercise? No Yes, If yes, then how often? Daily 2-3 times a Week Monthly

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of Last Menstrual Period: ____/____/____

(Signature) _____
(Date)

(Patient Signature. If minor, parent or guardian signature)

(Date)

Name _____ Date: ____/____/____

Office Billing Policy Regarding Treatment of Patients Involved in Automobile Collisions

At your initial appointment we require that you provide us your Auto Insurance information and the Insurance information of any at fault party. This includes: names of Auto Insurance Companies, claim numbers, claim managers names, phone numbers, etc.

Personal Injury Protection (PIP)

If you have Personal Injury Protection (PIP) on your auto insurance policy it is Primary and must be billed 1st. PIP is an optional benefit on most if not all auto insurance policies. You pay a specific additional monthly premium to have PIP on your auto policy. Washington State requires auto insurers to include the PIP protection option on your policy unless you specifically sign a waiver refusing it. Many if not most people in Washington State have PIP on their policy. Your general health insurance will not pay for your auto injury related treatment if or while you have unused PIP benefits.

General Health Insurance

If you do not have Personal Injury Protection (PIP) on your Auto Policy your General Health Insurance Plan may pay for some of your care. However, before they will pay you must inform them that you were in an Auto Collision and provide them proof that you do not have Personal Injury Protection (PIP) on your Auto Policy. In most cases they will require you to sign a document indicating that you do not have (PIP) and allowing them to subrogate (get paid back) when there is a settlement with the insurance company of the individual that caused your accident. Your General Health Insurance coverage is limited by your health plan benefits, deductibles, co-pays, co-insurance, etc.

Third Party Claim

The Third Party is the party at fault when someone else caused your accident. If you do not have Personal Injury Protection (PIP) and you do not have General Health Insurance what you're left with is possibly a Third Party Claim against the party that caused the collision and/or possibly a Uninsured Motorist Claim against your own Auto Insurance Policy. **Third Party and/or Uninsured Motorist Policy's do not pay for treatment until all of your treatment is concluded and there is a settlement of the claim. In some cases this can be 1-2 years or longer after the collision.**

Under the following conditions and on an individual basis we sometimes accept Third Party and/or Uninsured Motorist claims and we wait for payment until treatment is concluded and your claim is settled:

- 1) There are no other payment sources**
- 2) The patient has legal representation**
- 3) We file a Medical Lien against settlement proceeds from the at fault insurance company.**

I _____ have read and accept the above Billing Policy's.

Sign _____ Date _____

Name _____ Date: ____/____/____

Insurance Information

Who was at fault for the accident? _____

Do you have Auto Insurance (Personal Injury Protection)? If so, please fill in the following:

Name of your insurance: _____

Claims office address: _____

Claim #: _____ Phone number of your insurance: _____

Name of your adjustor: _____

Name of insurance for the other involved party/3rd Party: _____

Claims office address: _____

Claim #: _____ Phone number of insurance company: _____

Name of the adjustor: _____

If you have an attorney, please fill out the following:

Name of Attorney: _____

Address: _____

Phone Number: _____

Assignment of Insurance Benefits

I hereby authorize payment directly to Rainier Valley Chiropractic P.S. for the treatment of _____
(Patient Name)

I understand that I am financially responsible to the doctor for charges not covered by this assignment.

(Signature of Policy Holder or Patient)

____/____/____
(Date)

Authorization to Release Records to PIP

I hereby authorize Rainier Valley Chiropractic P.S. to send treatment records relating to the injury of
____/____/____ to my Personal Injury Protection carrier.
(Injury Date)

(Signature of Policy Holder or Patient)

____/____/____
(Date)

Personal Injury Protection and Third Party Settlements/ Auto

I hereby authorize payment directly to Rainier Valley Chiropractic P.S. for Chiropractic care relating to the injury of
____/____/____ to my Personal Injury Protection carrier. I understand that Rainier Valley Chiropractic P.S. (RVC)
will file a medical lien if I have a 3rd party only claim and/or if my Personal Injury Protection (PIP) benefits have been
exhausted. Liens are released after the claim settles and proceeds due RVC are received.
(Injury Date)

(Signature of Policy Holder or Patient)

____/____/____
(Date)

Name _____ Date: ____/____/____

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) _____ DOB _____ SSN _____

INFORMATION TO BE RELEASED FROM:

1) Name of facility or provider _____ Ph# _____ Pt. Initials _____
 Address _____ Fax# _____ Date Sent ____/____/____

2) Name of facility or provider _____ Ph# _____ Pt. Initials _____
 Address _____ Fax# _____ Date Sent ____/____/____

3) Name of facility or provider _____ Ph# _____ Pt. Initials _____
 Address _____ Fax# _____ Date Sent ____/____/____

INFORMATION TO BE SENT TO:

**Rainier Valley Chiropractic, P.S.
4236 36th Avenue S., Seattle, WA 98118
206-723-2820 (fax # 206-722-3664)**

INFORMATION TO BE RELEASED: (check one)

The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
 All medical records
 Specific information (please specify): _____

PURPOSE FOR WHICH THE DISCOURSE IS BEING MADE: (please check one)

Attorney Insurance Doctor Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

Drug/Alcohol abuse/treatment & diagnosis Sexually transmitted disease
 HIV/AIDS diagnosis/treatment testing Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

This authorization will expire 90 days from the date signed