RAINIER VALLEY CHIROPRACTIC P.S. 4236 36th Avenue S. Seattle, WA 98118
David A. Butters D.C. — Natasha Butters D.C. Phone 206-723-2820 Fax 206-722-3664

Auto Collision Patient History

Date ______________________ Phone Number______________________ 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:**___________________

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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 ❑Vomitting ❑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***
❑Headache	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Neck Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Shoulder Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Arm Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Mid Back Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Low Back Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Hip Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Leg Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Other ______________________________							0 1 2 3 4 5 6 7 8 9 10
❑Other ______________________________							0 1 2 3 4 5 6 7 8 9 10

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Name____ Date: _____/_____/_________

Health History

Cardiovascular/ Pulmonary/Respiratory:

❑Heart/vascular conditions ❑ History of stroke ❑Low blood pressure ❑High blood pressure ❑Difficulty breathing
❑Lingering 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)
____
____

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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.

Activity				
❑Sleeping	Minimal	Mild	Moderate	Severe
❑Sitting	Minimal	Mild	Moderate	Severe
❑Walking	Minimal	Mild	Moderate	Severe
❑Standing	Minimal	Mild	Moderate	Severe
❑Lifting	Minimal	Mild	Moderate	Severe
❑Household Chores	Minimal	Mild	Moderate	Severe
❑Routine Personal Care	Minimal	Mild	Moderate	Severe
❑Other ____________________	Minimal	Mild	Moderate	Severe
❑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)***

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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)*

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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 # 207-722-3664)

INFORMATION TO BE RELEASED: **(check one)**

__X__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 DISCOSURE IS BEING MADE: (please check one)

______ Attorney _______Insurance __X__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 ma 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