PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Last Name:	**MI:** **First Name:**	
Home Address:		
City:	State:	Zip:
E-Mail:	Cell Phone:	Text: Yes No
Date Birth: Age: Gender M F	Social Security No:	
Employer:	Work Phone:	
Emergency Contact:Name:	Relationship:	
Address:	Phone:	

AUTOMOBILE INSURANCE INFORMATION

Is there insurance coverage for the vehicle you were in? ☐Yes ☐No	☐ I have, ☐ Someone else has coverage. Name of person policy is under:
How is this person related to you? ☐ Self, ☐ Parent ☐ Friend ☐ Other	
Name of your Auto Insurance Carrier:	
Have you reported this injury to your insurance carrier? ☐ Yes, ☐ No	
Claim Adjusters Name:	Claim Adjuster's phone #:
Claim #:	
Were the police called to the scene? ☐yes ☐no	Was Either Driver Cited by Police?
Driver of Other Vehicle:	
Their Insurance Company:	Their Insurance Phone #:

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

<u>Our office will provide insurance billing services for you if you so desire as a courtesy</u>.

Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Your signature on this document indicates that you:

1) *Agree to pay for any outstanding bills incurred in this office.*
2) *Authorize the release of information necessary to secure the payment of benefits.*
3) *Authorize insurance payments to be made directly to Summit Chiropractic & Massage.*
4) *Authorize the use of this signature on all insurance submissions.*
5) *Authorize us to communicate through text/email. (Treatment related only and will NOT be shared)*

Do you have an attorney representing you? ☐ No ☐ Yes provide information:	Attorney Name: _____ Address_____ Telephone:

Signature of responsible party (Patient or Parent)_____ Date _____

Patient Information
Summit Chiropractic & Massage
7302 NE 18th Street, suite #102, Vancouver WA 98661 * 360-750-7220

Name: _____ **Date:** _____

Welcome to Summit Chiropractic & Massage. We want you to enjoy life to the fullest of your potential.

Reason for your visit today (check all that apply):

❑ stay healthy ❑ peak performance ❑ wellness evaluation ❑ fix the problem ❑ pain relief only

Complete this section only if you have symptoms
(this will be necessary for most insurances)

Date problem began? _____

Describe how this problem began (fall, lift, etc.)?

_____

_____

_____

Circle your current pain level: **0 1 2 3 4 5 6 7 8 9 10**

Check how often do you experience your symptoms:

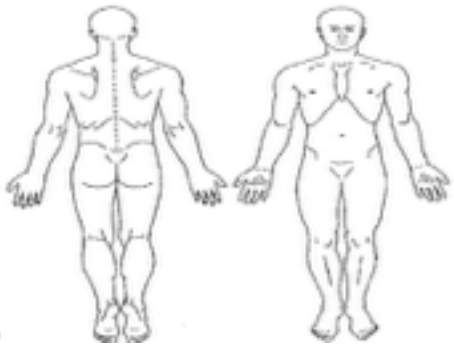
❑ Constantly (90-100%) ❑ Frequently (70-80%)
❑ Intermittently (40-60%) ❑ Occasionally (10-30%)
❑ 1x/month ❑ 2-3x/month ❑ 1x/week ❑ 2-4x/week ❑ Daily

Since it began is your complaint (circle): better worse same?

Does the complaint radiate anywhere? No Yes

If yes, Where? Leg Arm Other _____

Circle your current complaint area?



What best describes your complaint? (circle all that apply)

tension	stiffness	tightness
achy	sharp	burning
shooting	throbbing	stabbing
numbness	tingling	weakness
other:		

What makes your symptoms better _____

What makes your symptoms worse? _____

What daily activities are being affected? _____

Prior care/treatments? _____

Office/Doctor use

Summit Chiropractic & Massage Patient Information

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HAS YOUR COMPLAINT BEEN ASSOCIATED WITH OR HAVE YOU RECENTLY HAD:?

☐ **None of the following** Check all that apply.

☐ Recent excessive fatigue	☐ fever	☐ night pain / night sweats
☐ Unintentional weight loss/gain	☐ Change in bowel or bladder habits	☐ difficulty with talking/balance/confusion/dizziness
☐ Abdominal pain / pulsations	☐ Kidney pain / change in urination	☐ changes in vision (double/blurred)
☐ Chest pain / shortness of breath	☐ Weakness / numbness in a limb	☐ vomiting/diarrhea/constipation
☐ skin rash	☐ pain worse with rest	☐ other symptoms not mentioned:

SURGERY?

☐ **I have never had any surgery** If you have had any previous surgery, (circle) indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine surgery (neck or back)		☐ Cancer / chest / head / pelvis	
☐ shoulder / arm / hip / leg / hand / foot		☐ Other	

MEDICAL CONDITIONS / ILLNESS ?

☐ **I have no prior/current other conditions /illnesses.** Check all that you currently have or have ever had.

☐ Diabetes / Pre-Diabetes	☐ cancer (any type)	☐ heart attack / stroke	☐ heart disease
☐ scoliosis	☐ arthritis (anywhere)	☐ seizures / neurological	☐ osteoporosis / osteopenia (weak bones)
☐ herniated / degenerated discs	☐ high blood pressure	☐ abdominal aneurysm	☐ arm / leg numbness tingling weakness
☐ high cholesterol	☐ anxiety / depression	☐ asthma / allergies	☐ Crohn's / psoriasis / ulcerative colitis
☐ other conditions not mentioned:			

PRIOR INJURY HISTORY?

☐ **I have no history of previous painful injury.** If you have had prior injuries or pain, please check below:

☐ low back injury ☐ neck/mid-back injury ☐leg/arm injury ☐ sports injury ☐vehicle/motorcycle injury ☐ Other:
Details:

FRACTURES/BROKEN BONES?

☐ **I have never had any broken bones.** If you have broken any bones, indicate where and when:

Region	Year	Region	Year
☐ Spinal (neck/back)		☐ Skull / Pelvis	
☐ Arm / leg / foot / hand		☐ other:	

MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle relaxants/anti-inflammatory/steroids Details:	☐ Blood pressure/stroke /heart/cholesterol Detail:	☐ Diabetic Detail:
☐ Pain: prescription or over the counter Detail:	☐ Osteoporosis medications. Details:	☐ Other: Details:

LIFESTYLE

Rate the following:

Exercise/week: 1 2 3 4 5 6 7	**Diet:** poor / good / excellent
Stress level: Low Moderate High	**Tobacco:** yes / never / past

ILLNESSES / CONDITIONS IN YOUR FAMILY: _____

OCCUPATION _____ Physical demands _____

SIGNATURE _____ DATE _____

To the best of my ability, the information I have supplied is complete and truthful.

MOTOR VEHICLE CRASH FORM (Details)

Patient Name:_____ Date: _____

Date of injury:_____ Time of injury _____ ☐ AM ☐ PM

City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry

Street (location) where crash occurred: _____

What is the estimated damage to your vehicle? $_____ who made estimate?_____

Your vehicle? (model/make) Other vehicle? (model/make)

Impact Details ☐single car ☐2 vehicle ☐rear end ☐side ☐head-on ☐other

Your vehicle was: ☐slowing down ☐gaining speed ☐stopped ☐steady speed

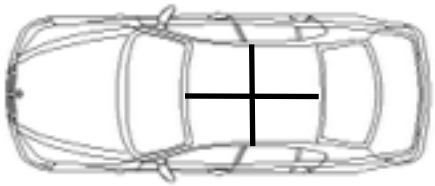
Other vehicle was: ☐slowing down ☐gaining speed ☐stopped ☐steady speed

During/after impact: ☐stayed straight ☐spun L / R ☐hit another object:

Describe crash: _____

_____

Mark area of damage to vehicle and X your sitting position



INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other

YES	NO	INDICATE THOSE RELEVANT TO YOUR CASE
☐	☐	Were you wearing a seatbelt? ☐Lap/shoulder ☐Lap only ☐no seatbelt in vehicle
☐	☐	Driver: Was your foot on the brake at impact?
☐	☐	Driver: Were you holding onto the steering wheel?
☐	☐	Was the door(s)/trunk/hood of your vehicle damaged to point where you could not open them?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes ☐side air bag ☐front air bag
☐	☐	Did you have any bruising after the crash? Where?

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all that apply.

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending crash and braced yourself before the collision.
☐	Your body, torso, and head were facing straight ahead.
☐	You had your head and/or torso turned at the time of collision: ☐ Turned to left, ☐ Turned to right Describe how far and why you were turned/what were you doing?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seat back If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso and body was positioned normally against the seat back with no gaps due to leaning/twisting

BEFORE AND AFTER INJURY PAIN COMPARISON FORM

PATIENT: _____ DATE: _____

For **section 1** please describe on a scale of 1-10 in how intense your pain level was 1 month prior to this injury and then indicate your current pain intensity. A zero indicates that no symptoms exist. A **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level or where pain while doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. An **8-10 pain** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks. For **section 2**, please relate the percentage of time you had pain 1 month prior to this injury and indicate your current percentage.

SECTION 1. PRIOR AND CURRENT PAIN INTENSITY LEVELS

First, ***SQUARE the box*** following the area of pain that best indicates your overall average-usual pain **before** this injury. Secondly, ***CIRCLE the box*** that indicates your **current** usual pain intensity.

PAIN INTENSITY	None	Minimum Discomfort/Ache/Stiff			Slight-to-Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

SECTION 2. PRIOR AND CURRENT PAIN FREQUENCY LEVELS

SQUARE the box following the area of pain that best indicates what average percentage of time you had pain **before** this injury. Secondly, ***CIRCLE the box*** that indicates your **current** typical pain frequency.

PAIN FREQUENCY	None	Occasional			Intermittent			Frequent		Constant	
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

HEADACHE AND/OR MIGRAINE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequent you had headaches and/or migraines. Be sure to indicate how many hours or days long each headache typically lasted.

How frequent did you have headaches 2-3 months before this injury?	_____ x week, _____ x month
How frequent do you have headaches currently?	_____ x week, _____ x month
How many hours or days did a typical headache last before this injury?	_____ Hours, _____ Days
How many hours or days do your typical headaches last currently?	_____ Hours, _____ Days
How much medication did you take prior to the accident typically?	_____ pills per week
How much medication do you take currently since the accident?	_____ pills per week

Functional Rating Index

Name: _____ For use with **Neck and/or Back Problems** **Date**: _____

(Print)

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0----------1----------2----------3----------4

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0----------1----------2----------3----------4

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0----------1----------2----------3----------4

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0----------1----------2----------3----------4

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0----------1----------2----------3----------4

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0----------1----------2----------3----------4

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0----------1----------2----------3----------4

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0----------1----------2----------3----------4

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0----------1----------2----------3----------4

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0----------1----------2----------3----------4

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Signature: _____ Total Score: _____ /40 _____ %

Summit Chiropractic & Massage * 7302 NE 18th Street, Vancouver, WA 98661 * 360-750-7220

Informed Consent

Patient: _____ date_____

Summit Chiropractic and Massage
Garry Pow DC
7302 NE 18th Street, Suite 102
Vancouver, WA 98661
360-750-7220

Congratulations on choosing chiropractic. It is among the safest of all the healthcare professions.

The Nature of Chiropractic Treatment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulation (CMT). I may use my hands or a mechanical instrument to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Various additional procedures, such as hot or cold packs, intersegmental traction and massage may also be used.

Material Risks Inherent in Chiropractic Treatment. As with any healthcare procedure, there are certain complications which may arise during CMT. These complications include but are not limited to: fractures, disc and joint injuries, muscle strains, Horner's Syndrome and cervical myelopathy. Studies have shown that any observed association between vertebral artery dissection (VAD) and stroke with cervical CMT is likely attributed to patients with an undiagnosed VAD who seek care for neck pain and headache before the onset of a stroke.(i) As a result we examine our patients thoroughly before initiating any treatment to be sure that treatment is appropriate. I will make every reasonable effort during the examination to screen for contraindications to care. Some patients may feel some stiffness and soreness following the first few days of treatment. The additional procedures could produce skin irritation, burns or minor soreness.

Probability of Risks Occurring. CMT is clearly one of the safest forms of treatment. Fractures are rare occurrences and generally result from existing underlying weakness of the bone which we screen for during the evaluation. The incidence of serious adverse events, stroke, or death is very rare.(ii) **Researchers found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care**.(iii) The risk was as low as 1.46 adverse events per 10,000,000 manipulations.(iv) The risk of artery dissection was as low as 1 per 5,846,381 cervical manipulations.(v) To put this in perspective, the probability is similar to being hit by lightning, dying in a plane crash or having serious complications caused by a *single* normal dose of aspirin or Tylenol. The other complications listed are also described as rare.

Spinal manipulation is safer than NSAID's by a factor of several hundred.(ix)

Other Treatment Options. Other treatment options for your condition may include:

* Self-administered, over-the-counter analgesics.

* Medical care with prescription drugs such as anti-inflammatory (NSAID), muscle relaxants and pain-killers

Medications: Some medications entail very significant risks - some with high probabilities. Medication can be used to reduce pain or inflammation. Long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. NSAIDS kill approximately 16,500 annually in the US.(vi) Tylenol toxicity is the leading cause of liver failure in the US.(vii,viii)

*Hospitalization/Surgery - Risk of exposure to communicable disease, iatrogenic mishaps and expense. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits to each and you may wish to further discuss details of these with your primary medical physician.

Summit Chiropractic and Massage

Informed Consent

Patient: _____ date_____

Garry Pow DC
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Risks of Remaining Untreated. Remaining untreated may allow the formation of adhesions, reduce mobility and increase degenerative changes which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non treatment will complicate a later rehabilitation is very high.(x-xv)

TREATMENT RESULTS

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function with an improved quality of life. However, I appreciate there is no certainty that I will achieve these benefits. No guarantee has been made to me regarding the outcome of these procedures.

Questions and/or concerns:

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have **read** and / or have **had the above explained** regarding the chiropractic adjustment and related treatment, alternatives and possible outcomes. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the recommended chiropractic care. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name _____ Patient's Signature_____

Signature of Parent or Guardian (if a minor) _____

Dated: _____

Doctor's Name _____ Signature _____