WESTERN NEW YORK CHIROPRACTIC LLC.
810 CENTER ROAD, WEST SENECA, NY 14224 (716) 674-4254 FAX: (716) 674-4392
WWW.WNYCHIROPRACTIC.COM

No Fault- Auto Accident

Please answer all questions completely. Failure to do so may delay the payment of necessary treatment and/or prevent the timely payment of wage loss benefits. You may be responsible for satisfying your deductible and for provider fees in the event your claim is denied.

A. Patient's Information

1. Name: _____ (First MI Last) 2. Social Security #: _____

3. Address: _____ (Street & Number City State Zip Code)

4. Home Phone: _____ 5. Cell Phone: _____ 6. Date of Birth: _____

7. How did you hear about WNY Chiropractic? (circle) Staff Ph. Bk. Screen/Health Fair Web Location Ad **OR**

8. Referred By: _____ (Patients Name and Relationship)

B. Accident Information

1. Date of accident: _____ 2. Time of accident: _____AM/PM

3. Were you the: ☐ Driver ☐ Passenger ☐ Rear Passenger

4. If a traffic violation was issued, to whom was it issued? _____

5. Did the police come to the accident site? ..... ☐ Yes ☐ No

Was a police report filed? ..... ☐ Yes ☐ No

Were there any witnesses? ..... ☐ Yes ☐ No

Were you wearing your seatbelt? ..... ☐ Yes ☐ No

Was the vehicle equipped with airbags? ..... ☐ Yes ☐ No

If yes, did it/they inflate? ..... ☐ Yes ☐ No

6. In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the base of the skull

7. What did your vehicle impact? ☐ Another vehicle ☐ Other: _____

8. Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, explain: _____

9. Make and Model of your vehicle: _____ 10. Make and model of other vehicle: _____

11. What was the approximate speed of your vehicle? _____MPH 12. Other vehicle: _____MPH

13. Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ right Side ☐ Left Side ☐ Other: _____

14. During impact, were you facing: ☐ Left ☐ Right ☐ Forward 15. Were you: ☐ Aware ☐ Surprised ☐ Other: _

16. Describe any treatment you received: _____

17. In your words, please describe the accident: _____

C. Insurance

1. Name of your car insurance company: _____ 2. Billing Address: _____ (Street & Number City State ZipCode)

3. Phone number of insurance company and agent's name: _____

4. Policy #: _____

SIGNATURE_____ **DATE**_____

For Doctor's Use Only									
C2	**C3**	**C4**	**C5**	**L2**	**L4**	**T2**	**P1**		
C	**TH**	**L**	**Right**	**Left**	**Wt.** _____	**Ht.**_____	**BP** _____		

F. After the Injury

1. Did the accident render you unconscious? ☐ Yes ☐ No If yes, For how long? _____

2. Were X-Rays taken? ☐ Yes ☐ No If yes, at what facility/hospital? _____

3. Was medication prescribed? ☐ Yes ☐ No If yes, list: _____

4. Indicate the symptoms that are a result of this accident:

	Dizziness		Difficulty Sleeping		Jaw Problems		Nausea
	Memory Loss		Irritability		Arm/Shoulder Pain		Back Pain
	Headaches		Fatigue		Numb Hands/Fingers		Lower Back Pain
	Blurred Vision		Tension		Chest Pain		Back Stiffness
	Buzzing in ear		Neck Pain		Stomach Upset		Numbness/Tingling
	Stiffness		Swelling		Weakness		Other:

5. Is your condition ☐ Getting Worse ☐ Constant ☐ Comes & Goes

6. Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

7. Have you retained an attorney? ☐ Yes ☐ No If yes, whom: _____ Phone #: _____

G. Recovery

1. How many hours are in your normal work day? _____

2. Please indicate your daily job duties and any activities which you are occasionally asked to perform:

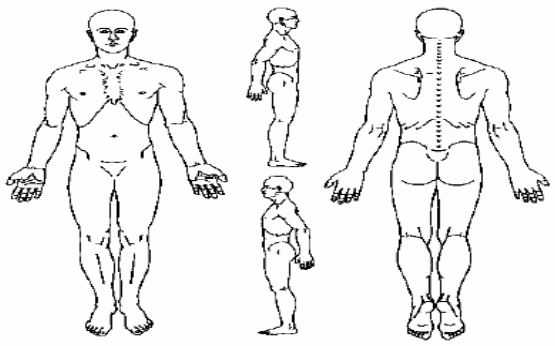
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Lifting
- ☐ Driving
- ☐ Twisting
- ☐ Crawling
- ☐ Bending
- ☐ Operating equipment
- ☐ Working with arms above head
- ☐ Typing
- ☐ Stooping
- ☐ Other: _____

3. Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No

4. While in recovery, is there any light duty work you could request? ☐ Yes ☐ No

5. My Pain Level right now: **No Pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
O = OTHER_____



On the diagram, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (See next to diagram) over the area of the body where those symptoms are occurring.

SIGNATURE_____ **DATE**_____

THIS IS A CONFIDENTIAL HEALTH REPORT

Please circle any of the following symptoms which you now have or have had previously

ALLERGIES None

- Environmental _____
- Food _____
- Medications_____
- Other _____

Gastro-Intestinal None

- Abdominal Pain
- Black Stool
- Bloody Stool
- Constipation
- Diarrhea
- Gall Bladder
- Hemorrhoids
- Liver Trouble
- Nausea
- Poor Appetite
- Vomiting Blood
- Vomiting Food
- Excessive Weight loss

Genital-Urinary System None

- Bladder Trouble
- Burning
- Cloudy Urine
- Discharge
- Discolored Urine
- Dribbling
- Excessive Urination
- Impotence
- Painful Urination
- Scanty Urination

Eyes None

- Blurred Vision
- Burning Eyes
- Cataracts
- Dryness
- Glasses
- Glaucoma
- Itchy Eyes
- Tearing
- Vision Headaches

Respiratory System None

- Congestion
- Coughing up Blood
- Difficulty Breathing
- Inhalant Exposure
- Non Productive Cough
- Phlegm
- Productive Cough
- Short of Breath
- Wheezing

Cardiovascular None

- Chest Pain
- Coughing Blood
- Coughing Phlegm
- Difficulty Breathing
- Heart Problem
- High Blood Pressure
- Low Blood Pressure
- Lung Problem
- Pain over heart
- Persistent cough
- Rapid Heart Beat
- Varicose Veins

Ear, Nose, Throat None

- Bleeding gums
- Dental Problems
- Deviated Septum
- Dry Mouth
- Ear Discharge
- Ear Noises
- Ear Pain
- Eye Inflammation
- Eye Strain
- Hearing Loss
- Hoarseness
- Nose Bleeding
- Nasal Discharge
- Recurrent infections
- Sore Gums
- Sore Throat
- Throat Pain
- Ulcers

Nervous System None

- Confusion
- Convulsions
- Depression
- Dizziness
- Fainting
- Hand Trembling
- Headaches
- Loss of Feeling
- Loss of Balance
- Loss of Memory
- Numbness
- Paralysis
- Seizures
- Tingling
- Weak grip

OSWESTRY DISABILITY INDEX

Name:_____ Age:_____ Date:_____ Raw Score:_____

Please complete this questionnaire by circling ***one*** answer in each section. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

SECTION 1 – Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	**SECTION 6 –Standing** A. I can stand as long as I want without extra pain. B. I can stand as long as I want but it gives me extra pain. C. Pain prevents me from standing for more than one hour. D. Pain prevents me from standing for more than half an hour. E. Pain prevents me from standing for more than ten minutes. F. Pain prevents me from standing at all.
SECTION 2 – Personal Care A. I can look after myself normally without causing extra pain. B. I can look after myself normally but it is painful. C. It is painful to look after myself and I am slow and careful. D. I need some help but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed, wash with difficulty and stay in bed.	**SECTION 7 – Sleeping** A. My sleep is never disturbed by pain. B. My sleep is occasionally disturbed by pain. C. Because of pain I have less than 6 hours sleep. D. Because of pain I have less than 4 hours sleep. E. Because of pain I have less than 2 hours sleep. F. Pain prevents me from sleeping at all.
SECTION 3 – Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights but it gives extra pain C. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table. D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. E. I can lift only very light weights. F. I cannot lift or carry anything at all.	**SECTION 8 – Social Life** A. My social life is normal and gives me no extra pain. B. My social life is normal but increases the degree of pain. C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc. D. Pain has restricted my social life and I do not go out as often. E. Pain has restricted social life to my home. F. I have no social life because of pain.
SECTION 4 –Walking A. Pain does not prevent me walking any distance. B. Pain prevents me walking more than one mile. C. Pain prevents me walking more than a quarter of a mile. D. Pain prevents me from walking more than 100 yards. E. I can only walk using a stick or crutches. F. I am in bed most of the time and have to crawl to the toilet.	**SECTION 9 – Traveling** A. I can travel anywhere without pain. B. I can travel anywhere but it gives extra pain. C. Pain is bad but I manage journeys over two hours. D. Pain restricts me to journeys of less than one hour. E. Pain restricts me to journeys of less than 30 minutes. F. Pain prevents me from traveling except to receive treatment.
SECTION 5 –Sitting A. I can sit in any chair as long as I like. B. I can sit in my favorite chair as long as I like. C. Pain prevents me from sitting for more than one hour. D. Pain prevents me from sitting for more than half an hour. E. Pain prevents me from sitting for more than ten minutes. F. Pain prevents me from sitting at all.	**SECTION 10 – Changing Degree of Pain** A. My pain is rapidly getting better. B. My pain fluctuates, but overall is definitely getting better. C. My pain seems to be getting better, but improvement is slow at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.

Patient Signature_____ Date_____

NECK DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may related to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing, etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all.

SIGNATURE:_____

DATE:_____

DISABILITY INDEX SCORE:_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) **(Signature of Provider)**

_____ _____
(Date of signature)

_____
(Address of Provider)

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	