Interurban Chiropractic
13028 Interurban Ave So. Suite 106
Tukwila, WA 98168-3340

Auto Accident Patient Information

Name _____ Today's Date _____

Address (No PO Box) _____

City _____ State _____ Zip _____

Cell Phone _____ H. Phone_____ W. Phone_____ (ok to call Y/N)

E-mail _____

Sex M F Date of Birth _____ (Age _____) Marital Status ☐ S ☐ M ☐ D ☐ W ☐ O

Social Security # _____ Referred By _____

Occupation _____Employer _____

DATE OF ACCIDENT _____ **Do you have PIP Coverage?** Yes☐No☐Amt _____

Your Auto Insurance Carrier _____ Claim # _____

Agent Name _____ Ph. _____

Auto Insurance Company of Other Driver _____Claim # _____

Agent Name _____ Ph. _____

****Please provide your HEALTH INSURANCE information to the Front Desk****

Other Occupants of Your Vehicle:

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Would you like to discuss chiropractic care for the other occupants of the vehicle? _____

Patient Name _____ Date _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ _____ ☐a.m. ☐p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐Rear Passenger Number of people in accident vehicle? _____

Make and model of the vehicle you were occupying? _____

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

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 a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/ they inflate? ☐ Yes ☐ No

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

What did your vehicle impact? ☐Another vehicle ☐ Other

If other, please explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the other vehicle(s) involved? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐Forward

Were you: ☐ aware or ☐surprised by the impact?

If accident vehicle made impact with another vehicle… Direction other vehicle was headed? ☐N ☐ S ☐E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

PRIOR TO INJURY

List any other Injuries, Traumas, Broken Bones and Surgeries you have had in the past, include dates:

_____

Are you taking any medications or supplements? Please list _____

_____

Do you have any Allergies: _____

Date of last physical exam: _____Height: _____ Weight_____Date of last chiropractic exam: _____

Females: Date of last menses: _____ Is there a possibility you could be pregnant? ☐YES ☐NO Please initial: ____

Any previous pregnancies? ☐YES ☐NO Any associated complications? Please list _____

Level of exercise, alcohol consumption, tobacco use and drug use: _____

Patient Name _____ Date _____

AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐Yes ☐ No

When did you go? ☐ Just after accident ☐The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ☐D.C. ☐M.D. ☐D.O. ☐ D.D.S.

Describe any treatment you received: _____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐Yes ☐No

Are your work activities restricted as a result of this injury? ☐Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Back pain	☐ Irritability	☐ Arms/shoulder pain	☐ Memory loss
☐ Headache(s)	☐ Fatigue	☐ Lower back pain	☐ Numb hands/ fingers
☐ Blurred vision	☐ Tension	☐ Back stiffness	☐ Buzzing in ear
☐ Neck pain	☐ Neck stiff	☐ Chest pain	☐ Ears ringing
☐ Leg pain	☐ Numb feet/ toes	☐ Stomach upset	☐ Fainting
☐ Loss of Memory	☐ Pins & Needles in Legs	☐ Pins & Needles in Arms	☐ Other (describe below)

_____

Is your condition getting worse? ☐Yes ☐ No ☐ Constant ☐ Comes and goes

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……	☐	☐	☐

Patient Name _____ Date _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐Other _____

What positions can you work in with minimum physical effort and for how long? ☐ N/A

_____

Prior to the injury were you capable of working on an equal basis with others your age? ☐Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐Yes ☐ No ☐ N/A

Recreation activities: _____

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #:_____

Address: _____

(Please note: an attorney is required if this is a 3rd party accident & there is no PIP coverage)

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- **I understand and agree that all services rendered to me are my financial responsibility and any health or accident insurance policies which I hold are based on a contract between the carrier and myself. I also understand that I am financially responsible for all non-covered services.**
- I authorize the staff to perform any necessary services needed during diagnosis and treatment in accordance with this state's statutes. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

☐Adult patient ☐Parent or Guardian ☐Spouse

Interurban Chiropractic
Helping people get the most out of life.

Terms of Acceptance

In order to provide the most effective healing environment and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

We, therefore, ask that you acknowledge the following points regarding Chiropractic care and the services that are offered through our clinic by initialing each statement below.

A) Chiropractic is a specific art and science that addresses the body's health concerns and needs through assessment and treatment of the various systems of the body, most notably, the **nervous system**. ____

B) Chiropractic seeks to maximize the **inherent healing** capacity of the human body by restoring normal nerve function through the adjustment of the **spine** and **extremities**. ____

C) The ***Chiropractic adjustment*** process involves the *application of a specific directional thrust to a region or regions of the* ***spine*** *and* ***extremities*** with the intent of repositioning misaligned segments. ____

D) A thorough **examination** and **full spine x-ray** is part of the standard Chiropractic procedure. The goal of this process is to identify any **spinal** and/or **extremity** health problems and to determine Chiropractic need. If, during this process, any condition or questions arise which are outside the scope of **Chiropractic treatment**, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need. ____

E) **Your compliance** with treatment plans, home exercise and other recommended self care is essential to **maximum healing** and optimal health through Chiropractic. ____

F) We invite you to **speak frankly** to the doctor and our staff on any matter related to your care to maintain a **supporting environment** during your time at our office. _____

Definitions:

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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Helping people get the most out of life.

IN OFFICE CLINICAL SUBMISSION FORM

Name: _____ **Patient ID#:** _____

Symptoms began on: ___/_____/_____

Patient Type:

- ☐ New Patient
- ☐ Established Patient, New Injury
- ☐ Established Patient, New Episode
- ☐ Established Patient, Continuing Care

Nature of the Condition:

- ☐ Initial Onset (Last 3 months)
- ☐ Recurring (Multiple Episodes < 3 months)
- ☐ Chronic (Continuous Duration > 3 months)

Cause:

- ☐ Traumatic
- ☐ Repetitive
- ☐ Post-Surgical
- ☐ Work Related
- ☐ Motor Vehicle
- ☐ Unspecified

If Post-Surgical

Type: ACL, Rotator, Tendon, Spinal Fusion, Joint replacement, Other

Date of Surgery: ___/___/____

Average Pain Intensity: (0 No Pain – 10 worst pain)

Last 24 hrs: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Past Week: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How often are your symptoms:

- ☐ Intermittently (0%-25%)
- ☐ Occasional (26%-50%)
- ☐ Frequent (51%-75%)
- ☐ Constant (76%-100%)

How much have your symptoms interfered with your day:

1 (Not at all) – 2 (A little) – 3 (Moderately) – 4 (Quite a bit) – 5 (Extremely)

☐ ☐ ☐ ☐ ☐

How much have you improved since starting care at this office:

1 (N/A) – 2 (Worse) – 3 (Worse) – 4 (Little Worse) – 5 ((Little Better) – 6 (Better) – 7 (Much better)

☐ ☐ ☐ ☐ ☐ ☐ ☐

How did your symptoms start:

_____
_____
_____
_____
_____

Current Overall Health:

1 (Excellent) – 2 (Very Good) – 3 (Good) – 4 (Fair) – 5 (Poor)

☐ ☐ ☐ ☐ ☐

Signature: _____ Date: ___/___/_____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name