

B. COMPLAINTS (CONTINUED)

7. Are You Getting? Better Worse Same

8. If Your Complaints Include Pain, Is It Aggravated By?

- Coughing
- Sneezing
- Straining At Stool
- Neck Movement
- Reaching
- Lifting
- Bending
- Sitting
- Standing
- Walking
- Other

9. If Your Complaints Include Pain, Is It Relieved By?

- Nothing
- Rest
- Ice
- Heat
- Stretching
- Exercise
- Sitting
- Standing
- Other

10. Have You Had Recent Treatment For This Condition?

Yes No If Yes, List Dates, Treatments, And Doctors:

11. Has This Condition Existed In The Past? Yes No

12. Since Your Symptoms Began, Have You Noticed A Change In?

In? If Yes, Indicate	Onset Date	Duration
<input type="radio"/> Bowel Function		
<input type="radio"/> Bladder Function		
<input type="radio"/> Sexual Function		

C. REVIEW OF SYSTEMS

1. Are You Presently Suffering (Or Within The Past Six Months Suffered) From Any Of The Following?

a. General

- Normal
- Fatigue
- Weakness
- Fever
- Loss Of Sleep
- Chills
- Weight Change
- Night Sweats
- Other

b. Skin

- Normal
- Rash
- Redness
- Itching
- Dryness
- Eczema
- Hair Changes
- Nail Changes
- Bruise Easily
- Other

c. Neurologic

- Normal
- Headache
- Dizziness
- Fainting
- Convulsions
- Nervousness
- Other

d. Eyes

- Normal
 - Vision Trouble
 - Pain
 - Discharge
 - Other
- | | |
|-----------------------|-----------------------|
| Right | Left |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |

e. Ears

- Normal
 - Hearing Trouble
 - Ringing
 - Pain
 - Discharge
 - Other
- | | |
|-----------------------|-----------------------|
| Right | Left |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
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| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |

f. Nose

- Normal
- Pain
- Bleeding
- Sinus Problems
- Infections
- Absence Of Smell
- Other

g. Mouth/Throat

- Normal
- Sores
- Bleeding
- Enlarged Glands
- Absence Of Taste
- Abnormal Taste
- Tonsillitis
- Other

h. Cardio-Vascular-Pulmonary (Heart/Lungs)

- Normal
- Cough
- Wheezing
- Difficulty Breathing
- Swollen Extremities
- Blue Extremities
- Varicosities
- Murmur
- Chest Pain
- Palpitations
- Other

i. Breasts

- Normal
- Lumps In Breast(s)
- Redness/Itching
- Pain
- Dimpling
- Discharge
- Other

j. Gastrointestinal (Stomach/Digestion)

- Normal
- Decreased Appetite
- Increased Appetite
- Abdominal Pain
- Hemorrhoids
- Excess Gas
- Vomiting
- Diarrhea
- Constipation
- Other

k. Genitourinary

- Normal
- Inability To Hold Urine
- Painful Urination
- Frequent Urination
- Bedwetting
- Irregular Menstruation
- Painful Menstruation
- Abnormal Vaginal Bleeding
- Impotence
- Sterility
- Prostate Problems
- Other

l. Endocrine (Metabolism)

- Normal
- Heat/Cold Intolerance
- Sugar In Urine
- Goiter
- Tremor
- Other

m. Psychologic

- Normal
- Anxiety
- Depression
- Memory Loss Or Impairment
- Phobias
- Mood Swings
- Other

NO MARKS HERE NO MARKS HERE NO MARKS HERE

C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies: Occasionally Frequently Constantly

1.

2.

3.

3. What Are Your Habits?

Smoking Never <1 1-2 2-3 3-4 5+

Alcohol Never <1 1-2 2-3 3-4 5+

Caffeinated Drinks Never <1 1-2 2-3 3-4 5+

Exercise Never <1 1-2 3-4 5-6 7

Drug/Substance Abuse Never Yes If Yes, Discuss With Doctor

D. MEDICAL HISTORY

1. Health Care

a. Have You Been To A Chiropractor Yes No

b. Do You Have A Family Physician Yes No

Date Of Last Physical Exam _____

Physician's Name & Address _____

c. Have You Been Hospitalized In The Past Five Years Yes No

Date & Reason For Hospitalization _____

d. Have You Had Surgery In The Past Five Years Yes No

Date & Reason For Surgery _____

e. Have You Had A Serious Accident In The Past Five Years Yes No

Auto Work Home Other

List Date & Describe Injury _____

f. Do You Have Any Drug Allergies Yes No

List Drugs _____

g. Are You Currently Taking Any Medication . Yes No

Anti-inflammatory (Aspirin, Motrin, etc.)

Muscle Relaxants Pain Medication/Analgesic

Tranquilizers Antibiotics

Blood Pressure Pills Other

Birth Control Pills _____

For What Condition/s Are You Taking Medication? _____

h. WOMEN ONLY:

To Your Knowledge Are You Pregnant Yes No

Have Your Past Pregnancies Been Normal Yes No

Are You Seeing An OB-GYN Regularly Yes No

Date Of Last Exam _____

Physician's Name & Address _____

2. If you now have or you had one of the following illnesses, please fill in EITHER bubble NH or bubble HH.

No Previous Conditions/Illnesses

<p>Now Have</p> <p>Have Had</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p> <p><input type="radio"/> <input type="radio"/> Asthma</p> <p><input type="radio"/> <input type="radio"/> Sinus Trouble</p> <p><input type="radio"/> <input type="radio"/> Hay Fever</p> <p><input type="radio"/> <input type="radio"/> Allergies</p> <p><input type="radio"/> <input type="radio"/> Tuberculosis</p> <p><input type="radio"/> <input type="radio"/> Diabetes</p> <p><input type="radio"/> <input type="radio"/> Epilepsy</p> <p><input type="radio"/> <input type="radio"/> Thyroid Trouble</p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Low Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Heart Trouble</p> <p><input type="radio"/> <input type="radio"/> Pacemaker</p> <p><input type="radio"/> <input type="radio"/> HIV/ARC</p> <p><input type="radio"/> <input type="radio"/> AIDS</p>	<p>Now Have</p> <p>Have Had</p> <p><input type="radio"/> <input type="radio"/> Sexually Transmitted Disease</p> <p><input type="radio"/> <input type="radio"/> Ulcer</p> <p><input type="radio"/> <input type="radio"/> Cancer</p> <p><input type="radio"/> <input type="radio"/> Polio</p> <p><input type="radio"/> <input type="radio"/> Rheumatic Fever</p> <p><input type="radio"/> <input type="radio"/> Serious Injury</p> <p><input type="radio"/> <input type="radio"/> Bone Fracture</p> <p><input type="radio"/> <input type="radio"/> Dislocated Joints</p> <p><input type="radio"/> <input type="radio"/> Spinal Disc Disease</p> <p><input type="radio"/> <input type="radio"/> Multiple Sclerosis</p> <p><input type="radio"/> <input type="radio"/> Scoliosis</p> <p><input type="radio"/> <input type="radio"/> Mental/Emotional Difficulty</p> <p><input type="radio"/> <input type="radio"/> Prostate Trouble</p> <p><input type="radio"/> <input type="radio"/> Kidney Trouble</p> <p><input type="radio"/> Other _____</p> <p><input type="radio"/> Other _____</p>
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3. Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Bad Posture	Present Age or Age at Death	Deceased
Father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bro 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bro 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bro 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sis 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sis 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sis 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Job Type

Full Time Temporary

Part Time Other _____

2. Work Week

Hours Per Day 1 2 3 4 5 6 7 8 9 10 11 12

Days Per Week 1 2 3 4 5 6 7

Other _____

3. Do Your Present Complaints Affect The Number Of Hours You Work Per Day Yes No

4. Length Of Time At Present Occupation

Years 10 20 30 40 50

1 2 3 4 5 6 7 8 9

Months 1 2 3 4 5 6 7 8 9 10 11

NO MARKS HERE NO MARKS HERE NO MARKS HERE

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)

5. Job Involves

- a. Lifting** 10 20 30 40 50 60 70 80 90 100+ Pounds
 Never Frequently
 Occasionally Constantly

b. Additional Job Requirements

- Bending Twisting Carrying
 Stooping Turning Walking
 Other _____

6. What Is Your Primary Work Position \ Location?

- a. Position:** Seated Standing Other _____
b. Location: Desk Counter Workbench Other _____

c. If Seated, What Type Of Chair Do You Use?

- Executive Steno Bench
 Stool Other _____

7. Do You Wear Shoes Or Boots With High Heels?

- Never Seldom Occasionally Frequently

8. Are You Right Or Left Handed?

- Right Left

9. Do Work Activities Aggravate Your Present Complaints?

- Yes No

10. Which Of The Following Best Describes Your Stress Level?

- None Minimal Moderate Great

11. How Do You Rate Your Physical Activity At Work?

- Seated more than 50% of workday
 Light Manual Labor
 Moderate Manual Labor
 Heavy Manual Labor

F. INSURANCE INFORMATION

1. Is Your Condition Due To:

- An Automobile Accident Yes No
A Personal Injury
A Job Injury

2. Do You Have Health Insurance Yes No

Company _____
Policy # _____

3. Is Your Spouse Employed Yes No

Business Address _____

4. Is Your Spouse The Primary Insured Yes No

Company _____
Policy # _____

5. HMO, PPO Plan Coverage Yes No

Company _____
Policy # _____

6. Are You Covered By Medicare Yes No

Medicare # _____

7. Authorization To Release Records To Patient's Insurance Carrier

Patient or Guardian's Signature _____

G. PAYMENT

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I WILL BE PAYING TODAY BY: (If paying by credit card please confirm which cards are accepted by our office.)

- Cash Check Visa
 MasterCard DiscoverCard American Express
 Other _____

Account # _____
Expiration Date _____

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Doctor's Signature _____ Date _____

Is There Anything Else You Would Like Us To Know?

Yes No



MARKS HERE

AUTOMOBILE CRASH QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: . Erase changes cleanly. Do not fold form.

Patient Name: _____

MO	DAY	YEAR	DR#	PATIENT NUMBER																	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A. VEHICLE YOU WERE IN

1. Vehicle type?

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

2. Vehicle size?

- Subcompact Full-Size
 Compact Mini
 Mid-Size Light
 Other _____

3. What was your location in the vehicle?

- Driver Front Passenger Rear Passenger
 Passenger Location: Left Middle Right
 Other _____

4. What was the vehicle you were in doing?

Mark only **ONE** bubble below to answer this question

a. Vehicle stopped for

- Traffic Light Intersection Stop Sign Traffic
 Pedestrian Parked
 Other _____

b. Vehicle slowing down for

- Traffic Light Intersection Stop Sign Traffic
 Pedestrian Turning Parking
 Other _____

c. Vehicle moving

- Slowly Moderately Fast
 _____ MPH Accelerating
 Other _____

d. Vehicle doing other

- Other _____

5. What damage did the vehicle you were in sustain?

- Minimal Moderate Extensive Totaled
 Unsure Other _____

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

b. Vehicle size?

- Subcompact Full-Size
 Compact Mini
 Mid-Size Light
 Other _____

c. How did this vehicle strike the vehicle you were in?

- Head On From Right From Left Rear Ended
 Sideswiped On Right Sideswiped On Left
 Other _____

d. What damage did this vehicle sustain?

- Minimal Moderate Extensive Totaled
 Unsure Other _____

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

b. Vehicle size?

- Subcompact Full-Size
 Compact Mini
 Mid-Size Light
 Other _____

c. How did this vehicle strike the vehicle you were in?

- Head On From Right From Left Rear Ended
 Sideswiped On Right Sideswiped On Left
 Other _____

d. What damage did this vehicle sustain?

- Minimal Moderate Extensive Totaled
 Unsure Other _____

3. Describe Other Vehicles To Strike Vehicle You Were In

- Vehicle Type: _____ How it struck: _____
 Vehicle Size: _____ Damage: _____

4. Were traffic citations issued as a result of the accident?

- No Citations issued Driver Of Other Vehicle
 Driver Of Vehicle You Were In You Unsure

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?

- Daylight Dawn Dusk Night
 Other _____

2. What was the condition of the road?

- Dry Damp Wet Snow Covered
 Icy Other _____

3. Visibility

a. What was the visibility at impact?

- Good Fair Poor
 Other _____

b. If visibility was poor, why?

- Sun Light Darkness Rain Snow
 Fog Traffic
 Other _____



D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

- Accident A Complete Surprise
 Aware Of Impending Collision And Braced For Impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? Yes No

b. Was it knocked off pedal by impact? Yes No

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? Yes No

2. What type of restraint belt were you wearing?

- Shoulder-Lap Belt Shoulder Belt Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? Yes No

2. What position was the headrest in?

- Low Middle High Don't Know

c. Air Bags

1. Was vehicle equipped with air bags?

- Yes No Unsure

2. Did the air bags deploy? Yes No

4. Your Body

a. What was your body position at impact?

- Straight Slouched Forward **Rotated:** Right Left
 Don't Recall Other

b. What direction was your body thrown?

- Forward\Backward Backward\Forward Sideways
 Across Vehicle Outside Vehicle Under Vehicle
 Don't Recall Other

5. Your Head And Neck

a. What position were your head/neck in at impact?

- Straight Tilted Forward **Rotated:** Right Left
 Don't Recall Other

b. Through what motion were your head/neck pitched?

- Forward\Backward Backward\Forward Sideways
 Don't Recall Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

- Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

b. Right Upper Extremity (Arm)

- Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

c. Left Upper Extremity (Arm)

- Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

d. Torso

- Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

e. Right Lower Extremity (Leg)

- Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

f. Left Lower Extremity (Leg)

- Steering Wheel Dashboard Windshield
 Right Side Door Left Side Door Armrest
 Right Window Left Window Headrest
 Ceiling Console Shift Lever
 Front Seat Rear View Mirror
 Other

2. Did your body strike any other objects?

Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature:

Date:

ACCIDENT / INJURY QUESTIONNAIRE

Dear Patient:

This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: . **Erase** changes cleanly. Do **not fold** form.

Patient Name: _____

MO	DAY	YEAR	DR#	PATIENT NUMBER																	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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A. DATE AND TIME OF ACCIDENT / INJURY

Date: / / Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

- Automobile Crash Questionnaire Marked (Skip Section B)
- Workmen's Compensation Accident / Injury
- Slip/Fall Accident Pedestrian Accident
- Other: Accident Injury

1. What was the cause of your accident / injury?

2. Describe in your own words what happened:

C. IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness?
- Yes No Don't Know
2. How did you feel?
- Confused Dazed Dizzy Nervous
- Weak Other
3. Where did you immediately develop pain?
- | | | |
|--|---------------------------------|--------------------------------|
| <input type="radio"/> Head | <input type="radio"/> Shoulders | <input type="radio"/> Buttocks |
| <input type="radio"/> Neck | <input type="radio"/> Arms | <input type="radio"/> Hips |
| <input type="radio"/> Upper / Mid Back | <input type="radio"/> Elbows | <input type="radio"/> Thighs |
| <input type="radio"/> Lower Back | <input type="radio"/> Forearms | <input type="radio"/> Knees |
| <input type="radio"/> Pelvis | <input type="radio"/> Wrists | <input type="radio"/> Legs |
| <input type="radio"/> Chest / Rib Cage | <input type="radio"/> Hands | <input type="radio"/> Ankles |
| <input type="radio"/> Abdomen | | <input type="radio"/> Feet |
| <input type="radio"/> Other | <input type="text"/> | |

4. If there were lacerations (cuts), where were they?

- | | | |
|--|---------------------------------|--------------------------------|
| <input type="radio"/> Head | <input type="radio"/> Shoulders | <input type="radio"/> Buttocks |
| <input type="radio"/> Neck | <input type="radio"/> Arms | <input type="radio"/> Hips |
| <input type="radio"/> Upper / Mid Back | <input type="radio"/> Elbows | <input type="radio"/> Thighs |
| <input type="radio"/> Lower Back | <input type="radio"/> Forearms | <input type="radio"/> Knees |
| <input type="radio"/> Pelvis | <input type="radio"/> Wrists | <input type="radio"/> Legs |
| <input type="radio"/> Chest / Rib Cage | <input type="radio"/> Hands | <input type="radio"/> Ankles |
| <input type="radio"/> Abdomen | | <input type="radio"/> Feet |
| <input type="radio"/> Other | <input type="text"/> | |

5. Describe any other significant injury:

6. Emergency Care At Accident/Injury Site

- a. Did you receive emergency care? Yes No
- b. What type of emergency care did you receive?
- Bandages Splints Brace Neck Collar
- Other

7. Destination After Accident / Injury

- a. Where did you go?
- Hospital Home
- School Work
- Other
- b. By whom were you driven?
- Myself Ambulance
- Friend Family Member
- Other

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

1. When did you go to the hospital?

Immediately Later That Day Next Day Days Later

Date / / Other

Hospital Name:

Examined By Doctor:

Admitted: Yes No Date Discharged: / /

2. If x-rays were taken, of what body part(s)?

- | | | |
|--|---------------------------------|--------------------------------|
| <input type="radio"/> Head | <input type="radio"/> Shoulders | <input type="radio"/> Buttocks |
| <input type="radio"/> Neck | <input type="radio"/> Arms | <input type="radio"/> Hips |
| <input type="radio"/> Upper / Mid Back | <input type="radio"/> Elbows | <input type="radio"/> Thighs |
| <input type="radio"/> Lower Back | <input type="radio"/> Forearms | <input type="radio"/> Knees |
| <input type="radio"/> Pelvis | <input type="radio"/> Wrists | <input type="radio"/> Legs |
| <input type="radio"/> Chest / Rib Cage | <input type="radio"/> Hands | <input type="radio"/> Ankles |
| <input type="radio"/> Abdomen | | <input type="radio"/> Feet |
| <input type="radio"/> Other | <input type="text"/> | |



D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

- Head Upper / Mid Back Chest / Rib Cage
 Neck Lower Back Abdomen
 Other _____

4. If a MRI was performed, of what body part(s)?

- Head Upper / Mid Back Chest / Rib Cage
 Neck Lower Back Abdomen
 Other _____

5. What was the diagnosis given at the hospital?

a. Head

- Concussion Skull Fracture Lacerations
 Contusions Other _____

b. Jaw

- Strain Sprain Dislocation
 Fracture Whiplash Lacerations
 Contusions Other _____

c. Neck

- Strain Sprain Dislocation
 Fracture Whiplash Disc Injury
 Lacerations Contusions
 Other _____

d. Upper / Middle Back

- Strain Sprain Dislocation
 Fracture Disc Injury Lacerations
 Contusions Other _____

e. Lower Back

- Strain Sprain Dislocation
 Fracture Disc Injury Lacerations
 Contusions Other _____

f. Pelvis

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

g. Chest / Rib Cage

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

h. Abdomen

- Strain Lacerations Contusions
 Other _____

i. Shoulders

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

j. Arms

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

k. Elbows

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

l. Forearms

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

m. Wrists

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

n. Hands / Fingers

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

o. Buttocks

- Strain Sprain Lacerations
 Contusions Other _____

p. Hips

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

q. Thighs

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

r. Knees

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

s. Legs

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

t. Ankles

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

u. Feet / Toes

- Strain Sprain Dislocation
 Fracture Lacerations Contusions
 Other _____

v. Other

- Strain Sprain Dislocation
 Fracture Lacerations Contusions

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- Oral Medication Sutures Splint Collar
 Injection Ice Packs Cast Support
 Topical Antiseptics Hot Packs Brace Surgery
 Bandages Other _____

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- General Practitioner Chiropractor Neurologist
 Physical Therapist Orthopedist Internist
 General Surgeon Plastic Surgeon
 Other _____

b. What recommendations were made?

- No Further Care No Follow-up Instructions Observation
 Rest Ice Heat Collar Support
 Time Off Work Other _____

c. Were medications prescribed?

- Pain Anti-inflammatory Antibiotic Nervousness
 Other _____

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- Immediately Hours That Evening Next Morning
 Days Week Month _____

2. What additional symptoms developed?

a. Head

- Pain Stiffness Numbness Tingling
 Other _____

b. Jaw

- Pain Stiffness Numbness Tingling
 Other _____

c. Neck

- Pain Stiffness Numbness Tingling
 Other _____

d. Upper / Middle Back

- Pain Stiffness Numbness Tingling
 Other _____

e. Lower Back

- Pain Stiffness Numbness Tingling
 Other _____

f. Pelvis

- Pain Stiffness Numbness Tingling
 Other _____

g. Chest / Rib Cage

- Pain Stiffness Numbness Tingling
 Other _____

h. Abdomen

- Pain Stiffness Numbness Tingling
 Other _____

i. Shoulders

- Pain Stiffness Numbness Tingling
 Other _____

j. Arms

- Pain Stiffness Numbness Tingling
 Other _____

k. Elbows

- Pain Stiffness Numbness Tingling
 Other _____

l. Forearms

- Pain Stiffness Numbness Tingling
 Other _____

m. Wrists

- Pain Stiffness Numbness Tingling
 Other _____

n. Hands / Fingers

- Pain Stiffness Numbness Tingling
 Other _____

o. Buttocks

- Pain Stiffness Numbness Tingling
 Other _____

p. Hips

- Pain Stiffness Numbness Tingling
 Other _____

q. Thighs

- Pain Stiffness Numbness Tingling
 Other _____

r. Knees

- Pain Stiffness Numbness Tingling
 Other _____

s. Legs

- Pain Stiffness Numbness Tingling
 Other _____

t. Ankles

- Pain Stiffness Numbness Tingling
 Other _____

u. Feet / Toes

- Pain Stiffness Numbness Tingling
 Other _____

v. Other

- _____

3. Since your accident / injury have you suffered from?

- Blurred Vision Chest Pain Nausea
 Double Vision Difficulty Breathing Vomiting
 Reduced Vision Palpitations Frequent Urination
 Impaired Hearing Constipation Inability To Hold Urine
 Ringing In Ears Diarrhea Painful Urination

E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

- Anxiety Convulsions Restlessness
- Depression Dizziness Insomnia
- Mood Swings Headaches Light Sensitivity
- Nervousness Fainting Reduced Appetite
- Poor Memory Loss Of Balance Weakness
- Tension Fatigue Weight Gain
- Other _____ Weight Loss

5. Are you restricted in any of the following areas as a result of this accident/injury?

- Daily Living Occupational/Work Recreational Activities
- Other _____

6. Have you missed work due to this accident / injury?

- Missed No Work Limited Work Activity
- Missed Work From: _____ To: _____
- Other _____

7. Did you self treat your symptoms?

- Ice Heat Bed Rest Over-The-Counter Medication
- Other _____

8. Did you seek medical care elsewhere?

a. General Practitioner Name: _____

Diagnosis And Treatment Recommendation:

b. Internist Name: _____

Diagnosis And Treatment Recommendation:

c. Chiropractor Name: _____

Diagnosis And Treatment Recommendation:

d. Neurologist Name: _____

Diagnosis And Treatment Recommendation:

e. Orthopedist Name: _____

Diagnosis And Treatment Recommendation:

f. General Surgeon Name: _____

Diagnosis And Treatment Recommendation:

g. Plastic Surgeon Name: _____

Diagnosis And Treatment Recommendation:

h. Psychologist Name: _____

Diagnosis And Treatment Recommendation:

i. Other Name: _____ Type: _____

Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

- CT Scan MRI Electrodiagnostic Studies
- Other _____

10. What is the reason for seeking today's consultation?

- Persisting Complaints Worsening Of Symptoms
- Other _____

F. INSURANCE / ATTORNEY INFORMATION

1. Have you contacted an insurance adjuster or representative regarding this claim?	Yes	No
<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Company: _____		
Adjuster: _____		
Claim #: _____		

2. Have you engaged services of an attorney?	Yes	No
<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Attorney: _____		
Address: _____		
City: _____ State: _____ Zip: _____		
Phone: _____		

3. Have you filed an accident / injury report?	Yes	No
<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

4. Have you filed for insurance benefits?	Yes	No
<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

NCS Pearson™ forms EW-227667-3:65

Patient's Or Guardian Signature: _____ **Date:** _____





Records Release Authorization

TO: _____ RE: _____

Following is a signed Records Release Authorization for the above-named patient. We would appreciate it if you would forward this information to the address below as soon as possible.

_____ Complete Medical Records

_____ X-Ray Records

I hereby authorize and request you to release the complete medical and/or x-ray records concerning my illness and/or treatment during the period from _____ to _____.

Signature _____ Date: _____

Thank you in advance for your prompt attention to this matter.

RELEASE FOR AUTO INFORMATION

Hernando Healthcare Associates, PA
8468 Northcliffe Blvd.
Spring Hill, FL 34606
Phone (352) 666-2222
Fax (352) 683-7284

I hereby authorize _____
(name of insurance company)

to release auto policy information including policy number, claim number, PIP and medpay benefits.

concerning the accident on: _____/_____/_____

Patient
name: _____

Signature of
patient: _____

Date: _____/_____/_____

**AUTHORIZATION TO RECOVER PERSONAL INJURY PROTECTION BENEFITS
and/or MEDICAL PAYMENTS COVERAGE ON BEHALF OF PATIENT:
ASSIGNMENT OF BENEFITS AND AUTHORITY TO RESERVE PIP and MED PAY
FOR MEDICAL BILLS AT ISSUE IN LAWSUIT**

I, the undersigned patient, hereby authorize the above entity to release any information in its possession it deems appropriate concerning my health/physical condition to any insurance company, its agents, representative or assigns to enable to collect any and all sums due and owing for services rendered. In the event any insurance company or other organization obligated to make personal injury protection/medical benefits payments to or for me for the fees charged by the entity denies a claim, reduces a claim, or otherwise fails to timely pay the fees charged, then I instruct to file suit against said insurance company on my behalf.

I, the undersigned patient, also agree to assign any and all causes of action for collection of Personal Injury Protection and/or Medical Payments coverage only. I also agree to assign any and all benefits available under my AAA or other additional roadside policies. This is not an assignment of all of my rights under the policy of insurance at issue.

I, the undersigned patient, also agree to allow the entity to reserve PIP and/or Med Pay benefits for all bills submitted by the entity.

I, the undersigned patient, also give the entity an irrevocable lien on any insurance proceeds to the extent that I have an outstanding balance with the medical provider except as specifically set forth in paragraph A.

- A. In consideration for the execution of this Authorization, does hereby agree as follows:
1. In the event a PIP suit and/or suit for Med Pay benefits is filed on my behalf, the undersigned facility, does agree to hold the undersigned patient liable for only those benefits that are not paid or not payable due to a lack of insurance. This means that if the entity files a PIP suit and does not prevail on the issues in the PIP suit, the undersigned patient is not responsible for the bills in issue. (Again to the extent that there is insurance coverage).

I also give my Doctor/Provider permission as Limited Power of Attorney to endorse any checks for moneys made payable to me for his/her services rendered for my treatment. I understand that by executing this Authorization, I am making an assignment of my personal injury protection/medical payment benefits pursuant to Fla. Stat. 627.736 (5).

Patient's Signature

Accepted by: Representative of the Entity

Terlep Chiropractic

FINANCIAL POLICY & CONSENT FORM

Thank you for choosing us as your health care providers. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require that you read, and sign prior to any treatment.

All patients must complete our Patient Information Forms prior to seeing the doctor. Full payment is due at the time of service. We accept cash, check and most major credit cards.

POLICY FOR MISSED APPOINTMENTS: A \$35.00 fee will be charged for any appointments missed without 24-hour prior notice. We request you notify us at least twenty-four (24) hours in advance of your scheduled appointment date and time.

Please be informed that although we will file insurance for you, the bill is ultimately your responsibility. Any insurance payment not received within 90 days will be billed directly to you.

MEDIGAP AUTHORIZATION FOR MEDICARE: A Medigap or Medicare Supplement policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

By your signature below, you request that payment of authorized MEDIGAP benefits be made on your behalf to any or all physicians treating you from Terlep Chiropractic for any services provided to you. You authorize any holder of hospital or medical information about yourself to release any information needed to determine these benefits payable for related services. You permit a copy of this authorization to be used in place of the original. The authorization is in force until it is either canceled or changed by you.

CONSENT FOR TREATMENT: By your signature below, you voluntarily consent to the rendering of care, including treatments and performance of diagnostic procedures. You understand that you are under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: By your signature below, you hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to you but not to exceed the physician's regular charges. You understand that you are financially responsible for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by you or your family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of your record(s) to any person or corporation which is or may be liable under a contract to the physician(s) or to you or to your family member or employer for all or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or your employer.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Terlep Chiropractic PA which I have read and understand. I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

By your signature below, you acknowledge you have read, reviewed and understand this policy.

Patient or Guardian Signature

Printed Patient Name

Date



**PATIENT
PREGNANCY
DISCLAIMER**

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At the present time,

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

_____ / ____ / ____
Signature - Patient Date

_____ / ____ / ____
Signature - Witness Date

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Terlep Chiropractic to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Terlep Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Terlep Chiropractic.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature:

Date

Parent/Legal Guardian Signature:

Date

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

Second Address: _____

City/State/Zip: _____

Phone: _____

Check months at this address:

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Notice of Privacy Practices for Protected Health Information

“This Notice Describes How Information About You may be used and disclosed and how you can get access to this information”. Please Review It Carefully

We safeguard information about your health and person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical uses and disclosures of medical information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- Required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker’s compensation

Patient privacy rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete

information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.

- Receive an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office.

Our responsibilities under HIPAA:

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change.

We May Contact You For Appointment Reminders.

You can complain about our policy or its execution:

This can be accomplished with a written statement to this office or the Secretary of Health and Human Services.