

CONFIDENTIAL PATIENT INFORMATION FOR AUTO ACCIDENTS

NAME: _____ DATE: _____

HOME PHONE: _____ WORK PHONE: _____

STREET ADDRESS: _____

CITY/STATE: _____ ZIP: _____ PO BOX # _____

AGE: _____ BIRTHDAY: _____ # OF CHILDREN: _____

MARITAL STATUS: S M W D SOCIAL SECURITY#: _____

NAME OF EMPLOYER: _____

OCCUPATION: _____ REFERRED BY: _____

NAME OF SPOUSE: _____ OCCUPATION: _____

NEAREST RELATIVE: _____ PHONE: _____

ADDRESS: _____

CITY/STATE: _____ ZIPCODE: _____

ARE YOU PREGNANT? YES NO PLEASE INITIAL HERE: _____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? YES NO

WHEN? _____ WHAT TYPE? _____

ANY HISTORY OF CANCER IN YOUR FAMILY? YES NO

SYMPTOM

SEVERITY (0=no pain, 10= emergency)

1. _____

2. _____

3. _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ am/pm

CITY OF ACCIDENT: _____ STREET OF ACCIDENT: _____

ROAD CONDITION AT THE TIME OF THE ACCIDENT: **WET DRY ICY OTHER:** _____

DID THE POLICE COME TO THE SCENE? **YES NO** IS THERE A REPORT? **YES NO**

DID YOU GO TO THE HOSPITAL **YES NO**

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of the body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during the accident? _____
What bruises did you sustain during this accident? _____

WHERE WERE YOU SEATED IN THE VEHICLE? _____

WERE YOU AWARE OF THE APPROACHING COLLISION PRIOR TO IMPACT, OR DID IMPACT
CATCH YOU BY SURPRISE? **AWARE** **SURPRISE**

DID YOU LOSE CONSCIOUSNESS UPON IMPACT? **YES** **NO**

IF SO, HOW LONG? _____

DID YOU EXPERIEECE A FLASH OF LIGHT OR EXPLOSION IN YOUR HEAD? **YES** **NO**

DID YOU BECOME: **CONFUSED** **DISORIENTED** **LIGHT HEADED** **DIZZY** **NAUSEATED**
BLURRED VISION **RING/BUZZ IN EARS** FROM THE ACCIDENT?

IF YOU STILL HAVE ANY OF THOSE SYMPTOMS, WHICH ONES? _____

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE FOLLOWING (please circle):

DIFFICULTY CONCENTRATING

IRRITABLE

RESTLESSNESS

DIFFICULTY WITH MEMORY

SLEEPLESSNESS

FORGETFULNESS

REDUCED TOLERANCE TO HEAT

REDUCED TOLERANCE TO ALCOHOL

HOW FAR IS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD?
(approximately) _____ inches **ABOVE** **BELOW**

WERE YOU WEARING A SEATBELT? **YES** **NO**

If yes, was it a **LAPBELT** or a **SHOULDER-LAP BELT**?

LIST THE YEAR, MAKE AND MODEL OF THE VEHICLE YOU WERE IN:

YEAR: _____ MAKE: _____ MODEL: _____

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? **YES** **NO**

IF YES, WAS THE DRIVER'S FOOT ALSO ON THE BRAKE? **YES** **NO**

IF NO, THEN ESTIMATE THE SPEED OF THE VEHICLE YOU WERE IN: _____ MPH

IF YOUR VEHICLE WAS MOVING AT THE TIME OF IMPACT, WAS IT:

Slowing down? **YES** **NO**

Gaining speed? **YES** **NO**

Traveling at a steady rate of speed? **YES** **NO**

ON WHAT PART OF THE AUTOMOBILE DID ANY OF THE FOLLOWING BODY PARTS HIT?

Head hit _____ Chest hit _____

Right /left shoulder hit _____ right/left arm hit _____

Right/left hip hit _____ right/left leg hit _____

Right/left knee hit _____ other _____

DID YOU RECEIVE ANY INJURY OR BRUISE FROM THE SEAT BELT? **YES** **NO**

IF YES, THEN DESCRIBE: _____

WHAT IS THE ESTIMATED COST DAMAGE TO THE VEHICLE YOU WERE IN? \$ _____

HAVE YOU SEEN ANY OTHER HEALTH CARE PROVIDERS FOR YOUR INJURIES? **YES** **NO**

WHO	DATE	TEST/TREATMENT
_____ / _____ / _____		
_____ / _____ / _____		
_____ / _____ / _____		
_____ / _____ / _____		

DID YOU GO TO ANY HEALTH PROVIDER THE DAY OF OR THE DAY AFTER THE INJURY

YES NO IF YES, WHO _____

IS ANYONE STILL TREATING YOU FOR YOUR INJURIES? **YES NO**

WHO	DATE	TEST/TREATMENT
_____ / _____ / _____		
_____ / _____ / _____		
_____ / _____ / _____		

WHAT EXPENSIVE DIAGNOSTIC TEST HAVE YOU HAD?

MRI___ CAT SCAN___ X-RAYS___

WHAT PRESCRIPTION DRUGS ARE CURRENTLY TAKING? **NONE**

DRUG	REASON	FREQUENCY	DOSAGE	DURATION	HELPING?
_____ / _____ / _____ / _____ / _____ / _____					
_____ / _____ / _____ / _____ / _____ / _____					
_____ / _____ / _____ / _____ / _____ / _____					
_____ / _____ / _____ / _____ / _____ / _____					

WHAT NON-PRESCRIPTION/OVER THE COUNTER DRUGS ARE YOU CURRENTLY TAKING?

NONE

DRUG	REASON	FREQUENCY	DOSAGE	DURATION	HELPING?
_____ / _____ / _____ / _____ / _____ / _____					
_____ / _____ / _____ / _____ / _____ / _____					
_____ / _____ / _____ / _____ / _____ / _____					

LIST YOUR CURRENT COMPLAINS/SYMPTOMS

SYMPSONM SEVERITY (0=NO PAIN, 10=EMERGENCY)

1. _____
2. _____
3. _____
4. _____

PRIOR TO THIS ACCIDENT HAVE YOU BEEN INVOLVED IN ANY SIMILAR TYPES OF ACCIDENTS?

YES

NO

WHEN

DID YOU RECOVER

WHAT WERE YOUR RESIDUALS?

_____ / _____ / _____
_____ / _____ / _____
_____ / _____ / _____
_____ / _____ / _____

WORK HISTORY

AT THE TIME OF THIS INJURY DID YOU HAVE A JOB? **YES NO**

WHAT WAS THE NATURE OF YOUR JOB? _____

DID YOU MISS ANY WORK BECAUSE OF YOUR INJURIES? **YES NO**

HOW MUCH WORK DID YOU MISS? _____

HAVE YOU RETURNED TO WORK YET? **YES NO**

HAVE YOU ATTEMPTED TO RETURN TO WORK YET? **YES NO**

DID YOU LOSE YOUR JOB BECAUSE OF YOUR INJURIES? **YES NO**

DID YOU CHANGE JOBS BECAUSE OF YOUR INJURIES? **YES NO**

OVERALL, AT THIS TIME IS YOUR CONDITION:

BECOMING WORSE

REMAINING THE SAME

IMPROVING

IF IMPROVING, ESTIMATE APPROXIMATE OVERALL IMPROVEMENT TO DATE:

HAS YOUR INSURANCE COMPANY EVER BEEN NOTIFIED OF THE ACCIDENT? **YES NO**

WHAT IS THE NAME OF YOUR AUTO INSURANCE COMPANY? (or the driver in the car in which you were a passenger) _____

WHAT IS THE ADDRESS AND PHONE NUMBER TO THE INSURANCE COMPANY?

WHAT IS YOUR CLAIM NUMBER? _____ POLICY NUMBER? _____

WHAT IS THE NAME OF THE OTHER DRIVERS INSURANCE COMPANY?

ADDRESS AND PHONE NUMBER?

CLAIM NUMBER? _____ POLICY? _____

DID YOU HAVE AN ATTORNEY ADVISING YOU IN THIS CASE? **YES** **NO**

IF YES, WHAT IS HIS/HER NAME? _____

ADDRESS AND PHONE NUMBER? _____

ASSIGNMENT AND RELEASE

I UNDERSTAND AND AGREE ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND ANY HEALTH OR ACCIDENT INSURANCE POLICIES ARE BETWEEN THE INSURANCE CARRIER AND MYSELF. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. CHIROPRACTIC CARE CENTER WILL ASSIST IN PREPARING ANY NECESSARY FORMS OR REPORTS AND I AUTHORIZE THE CHIROPRACTOR TO RELEASE ANY INFORMATION REQUIRED.

PATIENT'S SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ DATE: _____

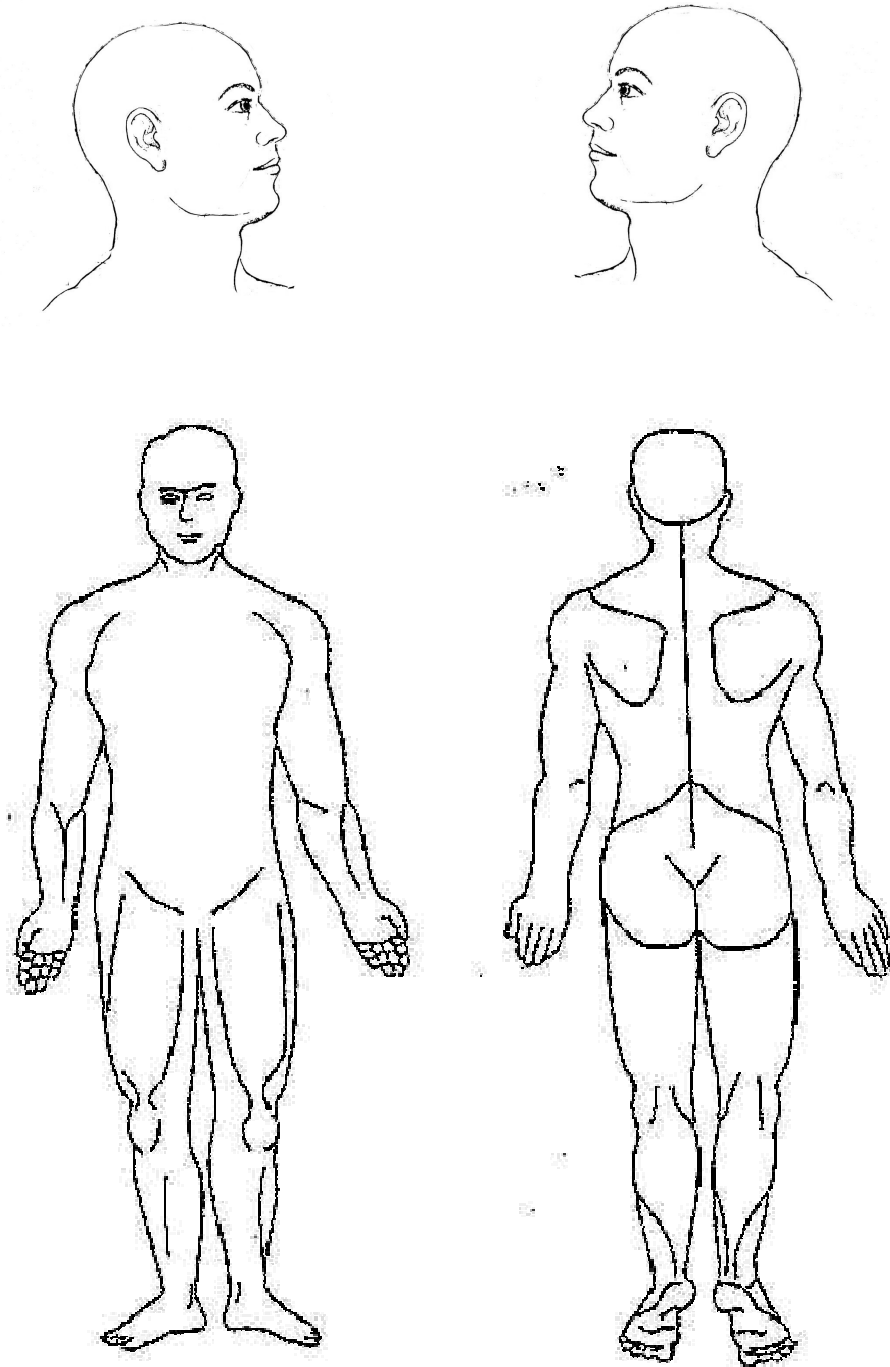
PAIN CHART

Please make the number on the drawing that most closely describes the sensations you feel.
Use arrows to show radiating pain or odd sensations. Fill this out very accurately.

- 1. numbness
- 2. tingling
- 3. burning

- 4. ache
- 5. sharp
- 6. throbbing

- 7. stabbing
- 8. pins and needles



PATIENT SIGNATURE: _____ DATE: _____

PATIENT CONSENT FORM

Chiropractic Care Center

Kenneth W. Trapp, D.C.

Marvin Kunikiyo, D.C.

Ryan J. Sweet, D.C.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to that extent that you have taken action relying on this consent.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

POLICY REGARDING
INSURANCE & FINANCIAL OBLIGATION

Payment is expected at the time of service. If you have insurance that covers chiropractic care, we will bill them as a service to you.

PLEASE CHECK ONE

_____ **NO INSURANCE.** Please be prepared to fully cover the fees for each visit by one the following way: Cash, Check, VISA OR MasterCard.

_____ **PRIVATE OR GROUP INSURANCE.** If your insurance covers chiropractic care you may still have to pay an annual deductible and/or co-pay at the time of service. We will bill your insurance for you and payment for your portion of the fees are due at the time of service and may be taken care of in one of the following ways: Cash, Check, VISA OR MasterCard.

_____ **MEDICARE OR** _____ **DSHS.** You will be required to pay for all services, which Medicare does not cover. Theses include: x-rays, exams and supplies such as ice, supports, etc. Payment for other non-covered services such as Maintenance or Preventative care will be your responsibility. Payment for these services can be taken care of in one of the following ways: Cash, Check, VISA OR MasterCard.

If you are covered under a secondary insurance, or a Medicare supplement we will submit bills to them as well.

_____ **AUTO ACCIDENTS.** If you have PIP (Personal Injury Insurance), your care is usually covered at 100%. It is our policy to bill your insurance under PIP regardless of whom was at fault. Any service or supplies not covered will become your personal responsibility. Please supply us with a claim number, billing address and telephone number, claim manager's name, attorney's name and any other information applicable.

If you do not have PIP, or you are waiting for the "at fault" party to reimburse you for medical expenses, as a service to you we will file a lien and wait for financial settlement to receive payment for our services. There is a \$9,00 fee for this service to cover the cost of filing a lien.

_____ **WORKER'S COMPENSATION.** The Washington Department of Labor and Industries will pay for 100% of services and supplies once your claim has been accepted. If Labor and Industries denies your claim you will be responsible for payment of services rendered. Any services provided to you after your claim closes will also be your responsibility.

If you have already opened a claim somewhere else, please provide us with the correct claim number, date of injury, name of your claim's manager, and name of the doctor you were previously seeing for this injury.

I have read and understand the Policy Regarding Insurance and Financial Obligation.

SIGNED: _____ DATE: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____

Date: _____