Auto Accident History Form

Patient's Name_____Today's Date_____DOB _____Date of Injury_____
Patient Address_____
Phone (H)_____ (C)_____Email _____
Insurance Company_____Insurance Company Contact Name_____
Claim #_____ Ins. Ph. #_____ Fax #_____

General information

Marital status: ☐married ☐single ☐divorced ☐widowed ☐separated ☐partnered
Smoke: ☐none pack/day_____years_____
Alcohol: ☐none # drinks_____per day/week/month

Employment status

At time of accident, where did you work?_____☐Unemployed
Where do you currently work?_____☐Unemployed
If unemployed, is it due to injuries from the accident? ☐yes ☐no
What activities does your work require?_____

Accident details

You were: ☐driver ☐front passenger ☐rear passenger ☐pedestrian ☐bicyclist
Your vehicle(yr./make/model)_____
Your estimated speed at time of accident: ☐stopped ☐slowing ☐accelerating
Location/street _____
Direction of travel: ☐N ☐S ☐E ☐W
Impact came from: ☐front ☐rear ☐L ☐R other_____
Other vehicle(yr./make/model)_____
Time of day_____
Road conditions: ☐dry ☐damp ☐wet ☐icy ☐snow
Body position at impact:
Head: ☐forward ☐R ☐L ☐up ☐down
Body: ☐forward ☐R ☐L ☐up ☐down
Head rest position: ☐up ☐down ☐don't know
Lap belt: ☐on ☐off Shoulder harness: ☐on ☐off
Aware of impending crash? ☐Y ☐N
Was seat broken by impact? ☐yes ☐no ☐don't know
Was your vehicle equipped with an airbag? ☐Y ☐N
If yes, did it inflate? ☐Y ☐N
Were you struck by the airbag? ☐Y ☐N
If yes, where were you struck?_____

Accident diagram:

General Description of Accident:

During the accident

Did you strike any parts of the vehicle? ☐Y ☐N If yes, describe._____
Did your vehicle strike any objects after initial impact? ☐Y ☐N If yes, describe._____
Was your vehicle pushed in any direction by the impact? ☐Y ☐N If yes, describe._____
Were you wearing a hat or glasses before impact? ☐Y ☐N If yes, were they still on after the impact? ☐Y ☐N
Did the accident render you unconscious? ☐Y ☐N If yes, how long?_____
Were the police on the scene? ☐Y ☐N Was an accident report filed? ☐Y ☐N
Estimated property damage to your vehicle. $_____
Estimated property damage to other vehicle. ☐None ☐Mild ☐Moderate ☐Major

After the accident

Please describe how you felt immediately after the accident:_____
_____
_____

Were you seen by a doctor or did you go to a hospital after the accident? ☐Y ☐N When did you go? ☐Just after the accident ☐The next day _____days later How did you get there? ☐Ambulance ☐Private transportation_____

After the accident---continued

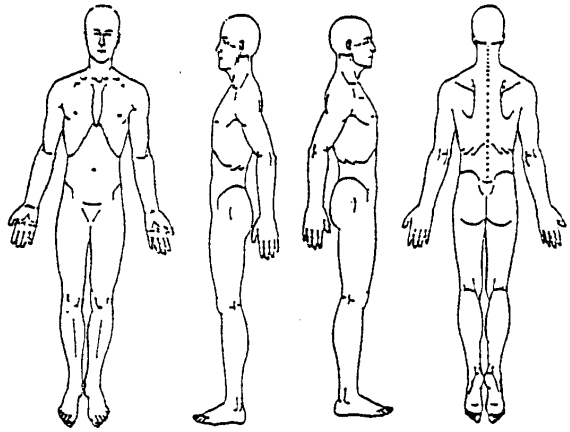
Name of hospital and/or attending doctor:
Were X-rays taken? ☐Y ☐N _____ Was medication prescribed? ☐Y ☐N _____
Have you been able to work since the injury? ☐Y ☐N Are your work activities restricted as a result of your injuries? ☐Y ☐N

Please indicate with a check mark, all of the symptoms which you feel are a result of this accident. In the columns to the right, fill in the appropriate information for each of the symptoms you checked.

Symptoms	How long after accident did symptoms begin?	Is this condition getting worse?	How frequent are the symptoms?	-Rate the Discomfort from 0-10 (0=no pain, 10=worst pain ever) -And describe the type of the pain
☐ Neck pain		☐Y ☐N	☐Constant ☐Intermittent	
☐ Headache		☐Y ☐N	☐Constant ☐Intermittent	
☐ Fatigue		☐Y ☐N	☐Constant ☐Intermittent	
☐ Memory loss		☐Y ☐N	☐Constant ☐Intermittent	
☐ Blurred vision		☐Y ☐N	☐Constant ☐Intermittent	
☐ Ears ringing		☐Y ☐N	☐Constant ☐Intermittent	
☐ Neck stiff		☐Y ☐N	☐Constant ☐Intermittent	
☐ Difficulty sleeping		☐Y ☐N	☐Constant ☐Intermittent	
☐ Numb hands/fingers		☐Y ☐N	☐Constant ☐Intermittent	
☐ Jaw problems		☐Y ☐N	☐Constant ☐Intermittent	
☐ Mid-back pain		☐Y ☐N	☐Constant ☐Intermittent	
☐ Low back pain		☐Y ☐N	☐Constant ☐Intermittent	
☐ Leg pain		☐Y ☐N	☐Constant ☐Intermittent	
☐ Numb feet/toes		☐Y ☐N	☐Constant ☐Intermittent	
☐ Tingling in extremities		☐Y ☐N	☐Constant ☐Intermittent	
☐ Nausea		☐Y ☐N	☐Constant ☐Intermittent	
☐ Irritability		☐Y ☐N	☐Constant ☐Intermittent	
☐ Dizziness		☐Y ☐N	☐Constant ☐Intermittent	
☐ Chest pain		☐Y ☐N	☐Constant ☐Intermittent	
☐ Shortness of breath		☐Y ☐N	☐Constant ☐Intermittent	
☐ Confusion		☐Y ☐N	☐Constant ☐Intermittent	
☐ Difficulty swallowing		☐Y ☐N	☐Constant ☐Intermittent	
☐ Disorientation		☐Y ☐N	☐Constant ☐Intermittent	

Who have you seen *for this condition*	**Office use in this column**
Doctor's name/specialty:	Dx:
Address:	Tx:
City: State: Zip:	X-rays/Tests: Freq.: Dur.:
Currently treating? May we contact this Dr.?	Referred to/from:
Doctor's name/specialty:	Dx:
Address:	Tx:
City: State: Zip:	X-rays/Tests: Freq.: Dur.:
Currently treating? May we contact this Dr.?	Referred to/from:
Provide descriptions and dates of all past injuries or conditions:	these include: fractures, dislocations, concussions, surgeries, major injuries or illness, sprains, hospitalizations, accidents, chronic issues

Have you retained an attorney? □Y □N If so, whom?_____Phone_____

Recovery	**Mark all areas of current pain with an "X"**
To evaluate the effect that continuing work will have on your recovery, please complete the following: **How many hours are in your normal work day?_____** Please indicate your daily job duties and any activities which you are occasionally asked to perform: DAILY: OCCASSIONAL: □Standing □Standing □Driving □Driving □Operating equipment □Operating equipment □Working with arms over head □Working with arms over head □Walking □Walking □Lifting □Lifting □Other_____ What positions can you work in with minimal physical effort & for how long?_____□N/A	

NECK Index- the statements should be applied to how you feel from the shoulder blades and UP.

Patient Name_____Date_____

This questionnaire will give your provider information on how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one that most closely describes your problem.

Pain Intensity
- ❒ I have no pain at the moment
- ❒ The pain is very mild at the moment
- ❒ The pain comes and goes and is moderate
- ❒ The pain is fairly severe at the moment
- ❒ The pain is very severe at the moment
- ❒ The pain is the worst imaginable at the moment

Sleeping
- ❒ I have no trouble sleeping
- ❒ My sleep is slightly disturbed (less than 1 hr sleepless)
- ❒ My sleep is mildly disturbed (1-2 hours sleepless)
- ❒ My sleep is moderately disturbed (2-3 hrs sleepless)
- ❒ My sleep is greatly disturbed (3-5 hrs sleepless)
- ❒ My sleep is completely disturbed (5-7 hrs sleepless)

Reading
- ❒ I can read as much as I want with no neck pain
- ❒ I can read as much as I want with slight neck pain
- ❒ I can read as much as I want with moderate neck pain
- ❒ I cannot read as much as I want because of moderate neck pain
- ❒ I can hardly read at all because of severe neck pain
- ❒ I cannot read at all because of neck pain

Concentration
- ❒ I can concentrate fully when I want with no difficulty
- ❒ I can concentrate fully when I want with slight difficulty
- ❒ I have a fair degree of difficulty concentrating when I want
- ❒ I have a lot of difficulty concentrating when I want
- ❒ I have a great deal of difficulty concentrating when I want
- ❒ I cannot concentrate at all.

Work
- ❒ I can do as much work as I want
- ❒ can only do my usual work but no more
- ❒ I can only do most of my usual work, but no more
- ❒ I cannot do my usual work
- ❒ I can hardly do wany work at all
- ❒ I cannot do any work at all

Personal Care
- ❒ I can look after myself normally without causing extra pain
- ❒ I can look after myself normally, but it causes extra pain
- ❒ It is painful to look after myself and I am slow and careful
- ❒ I need some help but I manage most of my personal care
- ❒ I need help every day in most aspects of self care
- ❒ I do not get dressed, I was with difficulty and stay in bed

Lifting
- ❒ I can lift heavy weights without extra pain
- ❒ I can lift heavy weights but it causes extra pain
- ❒ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned (e.g. on a table)
- ❒ Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
- ❒ I can only lift very light weights
- ❒ I cannot lift or carry anything at all.

Driving
- ❒ I can drive my care without any neck pain
- ❒ I can drive my car as long as I want with slight neck pain
- ❒ I can drive my care as long as I want with moderate neck pain
- ❒ I cannot drive my car as long as I want because of neck pain
- ❒ I can hardly drive at all because of severe neck pain
- ❒ I cannot drive my car at all because of neck pain

Recreation
- ❒ I am able to engage in all my recreation activities without neck pain
- ❒ I am able to do all my usual activities with some neck pain
- ❒ I am able to do most but not all of my usual activities because of pain
- ❒ I am only able to do a few of my usual activities because of pain
- ❒ I can hardly do any recreation activities because of neck pain
- ❒ I cannot do any recreation activities at all

Headaches
- ❒ I have no headaches at all
- ❒ I have slight headaches which come infrequently
- ❒ I have moderate headaches which come infrequently
- ❒ I have moderate headaches which come frequently
- ❒ I have severe headaches which come frequently
- ❒ I have headaches almost all the time

Index Score=
[sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index

Score

BACK Index- the statements should be applied to how you feel from the shoulder blades and DOWN.

Patient Name_____Date_____

This questionnaire will give your provider information on how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one that most closely describes your problem.

Pain Intensity
- ❒ My back pain comes and goes and is very mild
- ❒ The pain is mild and does not vary much
- ❒ The pain comes and goes and is moderate
- ❒ The pain is moderate and does not vary much
- ❒ The pain comes and goes and is very severe
- ❒ The pain is very severe and does not vary much

Sleeping
- ❒ I get no back pain in bed
- ❒ I get pain in bed but it does not prevent me from sleeping well
- ❒ Because of pain, my normal sleep is reduced by less than 25%
- ❒ Because of pain, my normal sleep is reduced by less than 50%
- ❒ Because of pain, my normal sleep is reduced by less than 75%
- ❒ Pain prevents me from sleeping at all

Traveling
- ❒ I get no pain while traveling
- ❒ I get some pain while traveling, but none of my usual forms of travel make it worse
- ❒ I get extra pain while traveling but it does not cause me to seek alternative forms of travel
- ❒ I get extra pain while traveling which causes me to seek alternative forms of travel
- ❒ Pain restricts all forms of travel except that done while lying down
- ❒ Pain restricts all forms of travel

Standing
- ❒ I can stand as long as I want without pain
- ❒ I have some pain while standing but it does not increase with time
- ❒ I cannot stand for more than 1 hour without increasing pain
- ❒ I cannot stand for more than 1/2 hour without increasing pain
- ❒ I cannot stand for more than 10 minutes without increasing pain
- ❒ I avoid standing because it increases pain immediately

Walking
- ❒ I have no pain while walking
- ❒ I have some pain while walking but it doesn't increase with distance
- ❒ I can not walk more than 1 mile without increasing pain
- ❒ I can not walk more than 1/2 mile without increasing pain
- ❒ I can not walk more than 1/4 mile without increasing pain
- ❒ I cannot walk at all without increasing pain

Personal Care
- ❒ I can look after myself normally without causing extra back pain
- ❒ I can look after myself normally, but it causes extra back pain
- ❒ It is painful to look after myself and I am slow and careful
- ❒ I need some help but I manage most of my personal care
- ❒ I need help every day in most aspects of self care
- ❒ I do not get dressed, I wash with difficulty and stay in bed

Lifting
- ❒ I can lift heavy weights without extra back pain
- ❒ I can lift heavy weights but it causes extra pain
- ❒ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned (e.g. on a table)
- ❒ Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
- ❒ I can only lift very light weights
- ❒ I cannot lift or carry anything at all.

Sitting
- ❒ I can sit in any chair as long as I like
- ❒ I can only sit in my favorite chair as long as I like
- ❒ Pain prevents me from sitting more than 1 hour
- ❒ Pain prevents me from sitting more than ½ hour
- ❒ Pain prevents me from sitting more than 10 minutes
- ❒ I avoid sitting because it increases pain immediately

Social Life
- ❒ My social life is normal and gives me no extra back pain
- ❒ My social life is normal but increases my degree of back pain
- ❒ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc)
- ❒ Pain has restricted my social life and I do not go out very often
- ❒ Pain has restricted my social life to my home
- ❒ I have hardly any social life because of my back pain

Changing Degree of Pain
- ❒ My pain is rapidly getting better
- ❒ My pain fluctuates but overall is definitely getting better
- ❒ My pain seems to be getting better but improvement is slow
- ❒ My pain is neither getting better nor worse
- ❒ My pain is gradually worsening
- ❒ My pain is rapidly worsening

Index Score=

Back

[sum of all statements selected / (# of sections with a statement selected x 5)] x 100 Index Score

Consent Form, Business Agreement, Insurance Information

1. Consent to Treatment

The nature of Chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use her hands or tools to adjust your joints and align your soft tissues. You may hear a "click or pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, Craniosacral therapy, traction, taping and exercise/nutritional instruction may also be employed.

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities includes muscular stain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment at this office. I accept the risks and benefits, and hereby give my full consent to treatment.

2. Privacy Policy

I understand that Dr. Anhorn DC may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it.

3. Cancellation and No Show Policy

I understand that without giving Dr. Anhorn DC 24 hours notice to cancel or change an appointment, full payment for the missed appointment will be due prior to my next appointment.

4. Release of Records/Payment Policy

Full payment is expected at the time of service. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to six months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize the doctor to release my medical records relating to claim for benefits submitted.

5. Authorization to Communicate via E-mail

Communication via e-mail can be convenient for all parties; however, e-mails may not be encrypted and could be read by some outside party with the skills to access this information.

By initialing here_____, I consent Cloud Chiropractic to communicate via e-mail in spite of the above.

Signature of Patient or Guardian_____ Date_____

Patient Name (please print)_____