intouchchiropractic

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Today's Date:_____ Referred By:_____

Patient Name:_____ Male Female File#_____

Social Security Number:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell:_____ Home:_____ Work: _____

Email:_____ Marital Status: S M W D

Spouse's Name:_____ Name(s) of Kids:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Phone Number:_____

Appointment Reminders: oEmail oText (Cell Phone Carrier: _____)

Previous Chiropractors:_____ Height:_____ Weight:_____

List Surgeries with Dates:_____

List Medications Prior to Collision:_____

Previous Injury/Trauma/Car Accidents. Provide Dates:_____

PLEASE PROVIDE A COPY OF YOUR PERSONAL HEALTH INSURANCE CARD TO THE FRONT DESK

If you have medical payments on your own personal automobile insurance policy <u>OR</u> have contracted an attorney, we can bill the responsible insurance company directly. For all other third party claims, please make payment at the time of service. I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred at the time of service.

Patient/Guardian Signature:_____ Date:_____

MOTOR VEHICLE COLLISION MECHANISM OF INJURY

Date of Collision:_____ Time of Day:_____ am pm

Road Conditions: Dry Wet Visibility: Poor Good

Were You: Driver Passenger Front Seat Back Seat

Year/Make/Model of Vehicle You Were In:_____

Year/Make/Model of Other Vehicle:_____

Please Describe the Collision:_____

_____

What Direction Were You Headed? North East South West Name of Street:_____

What Direction Was Other Vehicle Headed? North East South West Name of Street:_____

Were You Struck From: Behind Front Left Side Right Side

Approximate Speed of Your Car:_____mph Other Car:_____mph

Estimated Damage to Your Car: $_____ Estimated Damage to the Other Car: $_____

Were You Surprised by the Impact? Yes No If No, How Did You Brace? Hands Feet

If "Driver," Was Your Foot on the Break? Yes No Was Your Foot Knocked off the Pedal? Yes No

If "Driver," Were Your Hands on the Steering Wheel? Both/Left Hand/Right Hand

Were You Wearing a Seatbelt? Yes No Lap Belt/Shoulder Belt/Both

Does Your Car Have a Headrest? Yes No Headrest Set: Low Middle High

Does Your Car Have Airbags? Yes No Did They Deploy? Yes No

What Direction Was Your Head Facing at Impact? Straight Ahead/Turned Right/Turned Left

Did Any Body Part Strike Anything in the Vehicle at Impact? Yes No

Do You Have Bruises? Yes No Where?_____

What Part of Your Body Struck What?_____

Did Your Seat Break or Bend? Yes No

Immediately After the Collision:

Were You Knocked Unconscious? Yes No If Yes, For How Long?_____

Feel Pain? Yes No Where? Head Neck Upper/Middle Back Low Back

Loss of Range of Motion? Yes No Where? Neck Upper/Middle Back Low Back

Visual Disturbance? Yes No

Hearing Disturbance? Yes No

Dizziness/Vertigo? Yes No

Nausea? Yes No

Numbness? Yes No Where?_____

Please Describe How You Felt

LATER THAT DAY:_____

THE NEXT DAY:_____

Police and Ambulance:

Was the Collision Reported to the Police? Yes No Report? Yes No *provide report

Did You Go to the ER/Hospital? Yes No If Yes, When? _____

How Did You Get to the ER/Hospital? Ambulance/Police Car /Private Transportation

Were You Admitted? Yes No If Yes, How Long?_____

Name of Hospital? _____ Attending Dr. _____

What Treatment Did You Receive? (Circle all that apply)

None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandages / Cervical Collar / Physical Therapy / Labs

Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist

Referred to MD / Referred to Chiropractor / Other: _____

What Other Doctor(s) Have You Seen for This Injury? _____

Medications Taken AFTER the Collision _____

Self Treatment (e.g., bed rest, ice, etc.)_____

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE COLLISION

Neck Pain/Stiffness	Low Back Pain	Pain, Right Shoulder	Pain, Right Fingers
Neck Muscle Spasm	Sciatica, Right Side	Pain, Left Shoulder	Pain, Left Fingers
Numbness in Shoulders	Sciatica, Left Side	Pain, Right Elbow	Pain, Right Hip
Numbness in Arms	Numbness, Right Leg	Pain, Left Elbow	Pain, Left Hip
Numbness in Hands	Numbness, Left Leg	Pain, Right Forearm	Pain, Right Knee
Midback Pain	Numbness, Right Toes	Pain, Left Forearm	Pain, Left Knee
Numbness in Midback	Numbness, Left Toes	Pain, Right Wrist	Pain, Right Ankle/foot
Midback Muscle Spasm	Sleeping Problems	Pain, Left Wrist	Pain, Left Ankle/Foot
Rib Pain/Sprain	Difficulty Walking	Pain, Right Hand	Muscle weakness
Upset Stomach	Buzz/Ringing in Ears	Pain, Left Hand	Irritability/Nervousness
Loss of Taste	Loss of Smell	Loss of Memory	Anxiety

Have You Lost Time From Work As a Result of This Collision? Yes No Unemployed

If Yes, Last Day Worked:_____ Type of Employment:_____

Do You Have Difficulty: Standing / Walking / Riding / Bending / Twisting

Do You Have Difficulty Lifting: Light / Moderate / Heavy / Repetitive Loads

Since This Injury Occurred, Are Your Symptoms: Improving / Getting Worse / Same

Any Daily Activity Restrictions as a Result of This Injury? Yes No

Describe_____

Patient/Guardian Signature:_____ Date:_____

History Form:

Symptom 1 _____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time that you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% of the time

WHEN did the symptom begin? _____
Did the symptom begin suddenly? gradually? (circle one)

HOW did the symptom begin? _____

Did you have this symptom before this motor vehicle collision? Yes No
If so, what was the intensity (1-10 w/10 being the worst) and frequency? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward	Bending neck backward	Tilting head to the left	Tilting head to the right	Turning head to the left	Turning head to the right	Sitting
Bending forward at waist	Bending backward at waist	Tilting left at waist	Tilting right at waist	Twisting left at waist	Twisting right at waist	Standing
Getting up from sitting position	Getting up from laying position	Any movement	Driving	Walking	Running	Lifting
Nothing	Other:					

What makes the symptom better? (circle all that apply):

Rest	Ice	Heat	Stretching
Exercise	Massage	Pain Medications	Muscle Relaxers
Nothing	Other:		

Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning
Throbbing	Piercing	Stabbing	Deep
Nagging	Shooting	Stinging	
Other:			

Does the symptom radiate to another part of your body (circle one): Yes No
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day

History Form:

Symptom 2 _____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time that you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% of the time

WHEN did the symptom begin? _____
Did the symptom begin suddenly? gradually? (circle one)

HOW did the symptom begin? _____

Did you have this symptom before this motor vehicle collision? Yes No
If so, what was the intensity (1-10 w/10 being the worst) and frequency? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward	Bending neck backward	Tilting head to the left	Tilting head to the right	Turning head to the left	Turning head to the right	Sitting
Bending forward at waist	Bending backward at waist	Tilting left at waist	Tilting right at waist	Twisting left at waist	Twisting right at waist	Standing
Getting up from sitting position	Getting up from laying position	Any movement	Driving	Walking	Running	Lifting
Nothing	Other:					

What makes the symptom better? (circle all that apply):

Rest	Ice	Heat	Stretching
Exercise	Massage	Pain Medications	Muscle Relaxers
Nothing	Other:		

Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning
Throbbing	Piercing	Stabbing	Deep
Nagging	Shooting	Stinging	
Other:			

Does the symptom radiate to another part of your body (circle one): Yes No
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day

History Form:

Symptom 3 _____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time that you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% of the time

WHEN did the symptom begin? _____
Did the symptom begin suddenly? gradually? (circle one)

HOW did the symptom begin? _____

Did you have this symptom before this motor vehicle collision? Yes No
If so, what was the intensity (1-10 w/10 being the worst) and frequency? _____

What makes the symptom worse? (circle all that apply):

Bending neck forward	Bending neck backward	Tilting head to the left	Tilting head to the right	Turning head to the left	Turning head to the right	Sitting
Bending forward at waist	Bending backward at waist	Tilting left at waist	Tilting right at waist	Twisting left at waist	Twisting right at waist	Standing
Getting up from sitting position	Getting up from laying position	Any movement	Driving	Walking	Running	Lifting
Nothing	Other:					

What makes the symptom better? (circle all that apply):

Rest	Ice	Heat	Stretching
Exercise	Massage	Pain Medications	Muscle Relaxers
Nothing	Other:		

Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning
Throbbing	Piercing	Stabbing	Deep
Nagging	Shooting	Stinging	
Other:			

Does the symptom radiate to another part of your body (circle one): Yes No
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day

Patient Consent to Physical Examination and X-Rays

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

During your examination, the doctor may determine that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patient's consent for such tests.

I understand that the doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests, x-rays and physical examinations.

Patient/Guardian Signature: _____ **Date: _____**

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, health care provider's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way.

Patient/Guardian Signature: _____ **Date: _____**

Medical Insurance Information/Financial Responsibility

I hereby instruct and direct _____ Insurance Company to pay by check or EFT any insurance benefit payments to: Intouch Chiropractic, 2425 Camino Del Rio South #100, San Diego, CA 92108

In the event that a check(s) is/are mailed to me, or if my current policy prohibits direct payment to doctor, I understand that I am responsible for bringing the check(s) into the office <u>within 7 days</u> so that my account can be properly credited.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize the request of medical records, reports and imaging which are pertinent to the delivery of my care by this office. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Intouch Chiropractic provides its services directly to you, not your insurance company. I have read and understand that I am ultimately liable for my bill.

Patient Name:_____ **Date:_____**

_____ **Witness: _____**

Signature of Policyholder/Claimant, if other than Policyholder

Authorization for Care/Terms of Acceptance

I hereby authorize the doctor and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis.
When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 adjustment to the spine.

Health is a state of optimal physical, mental and social well-being not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more the joints of the body. This can cause pain or alteration of the nerve function and interference of the transmission of the nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than the 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. We do not and cannot promise or guarantee to cure any specific symptom, disease or condition. 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 subluxation.

I have read and fully understand the above statement. Any 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.
I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and collision insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. 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.

Patient/Guardian Signature: _____ **Date:_____**

Patient Consent for Use & Disclosure of Protected Health Information

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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 with healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

We use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area, or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient/Guardian Signature: _____ **Date:_____**

Informed Consent for Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events / per one million persons/ year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient/Guardian Signature: _____ **Date:_____**

Witness Name: _____

Consent for Treatment of Minors

I, being parent or guardian of _____, a minor the age of _____, do hereby authorize, request and direct Dr. Devin Young D.C. and/or Dr. Jeanett Tapia D.C. to perform an exam, x-ray and chiropractic treatment for their condition as he/she deems necessary. In addition, I give permission for the doctors to manage his/her care when I am not present to observe such care.

Patient/Guardian Signature: _____ **Date: _____**

Witness: _____

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PERSONAL INJURY PAYMENT POLICY

Who Was At-Fault?:

_____ I was at-fault for the collision

_____ Another person was at-fault for the collision

WE DO NOT ACCEPT THIRD-PARTY COLLISIONS WITHOUT ATTORNEY REPRESENTATION

Medical Payments:

_____ I have medical payments on my OWN auto insurance policy $_____max limits

_____ I do not have medical payments on my OWN auto insurance policy

Attorney Information:

_____ I have contracted an attorney

_____ I have not contracted an attorney

Attorney's Name:_____ Phone#:_____

Your Auto Insurance Information (not personal medical insurance)

Your Name:_____

Your Insurance Company:_____ Claim#:_____

Adjustor's Name:_____ Phone#:_____

Address: _____ Fax#:_____

Date of Collision:_____

Other Driver's Insurance Information

Other Driver's Name:_____

Other Driver's Insurance Company:_____ Claim#:_____

Adjustor's Name:_____ Phone#:_____

Address: _____ Fax#:_____

If you have medical payments on your own personal automobile insurance policy OR have contracted an attorney, we can bill the responsible insurance company directly. For all other third party claims, please make payment at the time of service. I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred at the time of service.

Patient/Guardian Signature:_____ Date:_____