PERSONAL INJURY PATIENT HISTORY

NAME______________________________ DATE__________ FILE#_______

ADDRESS ____________________CITY_________STATE____ZIP______

HOME PHONE ___________________ WORK PHONE _________________

DATE OF BIRTH ________ AGE______ MARITAL STATUS ___________

SOCIAL SECURITY _______________ SPOUSE'S FIRST NAME ________

In case of an emergency whom should we notify? _________________________
Address______________________ Phone ___________ Relationship________

INSURANCE INFORMATION *** *(Patients Auto Insurance Information)* ***

COMPANY NAME________________________ POLICY #_______________

ADDRESS______________________ CITY_________ STATE___ ZIP____

ADJUSTER'S NAME_________________________ PHONE____________

INSURED'S AUTO INSURANCE *(Driver/ owner of car you were in, if not yourself)*

NAME OF INSURED ___________________PHONE __________________

COMPANY NAME ___________________ POLICY ________________

ADJUSTER'S NAME__________________PHONE___________________

ADDRESS _________________ CITY_________ STATE____ ZIP______

INSURED'S HEALTH INSURANCE

COMPANY NAME___________________ ID#___________________

PHONE___________________ GROUP #_________________

ADDRESS___________________ CITY________ STATE___ ZIP______

Did you bring a copy of the police report? *YES NO N/A*
Did you bring all emergency room and other doctor's medical records regarding the accident? *YES NO N/A*

DATE OF ACCIDENT ____________ TIME _______AM/PM

Where were you seated? [ ] Driver's seat, [ ] Passenger front seat,
[ ] Middle front seat, [ ] Right back seat, [ ] Middle back seat, [ ] Left back seat

Who owns the car?__________________ Make/ Model of car____________

What approximate damage was done to the car you were in? $__________

Road conditions at the time of the accident: [ ] Icy, [ ] Wet, [ ] Clear, [ ] Dark

Your car: [ ] Hit another car, or [ ] Was hit in the R or L, Rear, Front, Side

Type of accident: [ ] Head on collision, [ ] Broadside (T-bone), [ ] Rearended,
(Check one) [ ] Front impact- rearended car in front of you, [ ] Non collision,
[ ] Other______________________________

Explain in detail how your accident occurred:____________________________
____
____
____

Were you prewarned the accident was about to happen? *YES* or *NO*

Did you brace for the impact? *YES* or *NO*

Were you wearing a seatbelt/ shoulder harness? *YES* or *NO*

Did your car have headrests? *YES or NO* If *YES*, what position were they in?
[ ] Top of headrest even with the bottom of your head
[ ] top of the headrest even with the top of your head
[ ] Top of the headrest even with the middle of the back

Was your car breaking? *YES or NO*

HEAD/ BODY POSITION AT THE TIME OF THE ACCIDENT: [ ] Head turned L or R
[ ] Head looking back, [ ] Head straight forward, [ ] Body straight in a sitting position,
[ ] Body rotated: L or R

Were your hands on the steering wheel at the time of the accident? *YES or NO*

Was your car pushed forward as a result of the accident? *YES or NO*
If *YES*, estimate distance____

Did your car hit anything else after the initial impact?_________________________

Indicate if your body part(*left* column) hit anything in the car (*right* column)
Draw lines matching the left side with the right side

Head	Windshield
Face	Steering wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car frame
Hip	Another occupant
Knee	Seat
Foot	Seatbelt
Hands	Sun visor

Was there any glass broken or shattered? *YES or NO*

CHECK if any of the following vehicle parts broke, bent or were damaged in the car: [ ] Windshield, [ ] Seat frame, [ ] Mirror, [ ] Steering wheel, [ ] Dash, [ ] Side / rear window, [ ] Other__________________________

Was the car towed from the accident? *YES or NO*
Was the car drivable? *YES or NO*

As a result of the accident were you: [ ] Rendered unconscious, [ ] Dazed,
[ ] Circumstances vague, [ ] Shaken but could function
[ ] Other____

Could you move all parts of your body? *YES or NO* if *YES*, what parts could you not move and why? ____

Were you able to get out of the car and walk unaided? *YES or NO* if *NO*, why not?____

Did you receive any bleeding cuts or bruises? *YES or NO* if *YES*, where? _________

Immediately after the accident how did you feel? _____________________________

Where were you taken after the accident?______________________________

By ambulance? *YES or NO*, Which hospital______________________________

Were you admitted? *YES or NO*

Were x-rays or any other tests performed ?______________________________

What treatment did you receive?______________________________

Did anything make you feel better?______________________________

Over the next 24 hours, how did you feel?______________________________

Did you receive any other medical treatment after the accident? *YES or NO* if *YES*, by whom?______________________________

Did this treatment help?______________________________

Symptoms after the accident: (check as many as applicable)

[ ] Headache
[ ] Neck pain/ stiffness
[ ] Arm pain numbness/ tingling
[ ] Mid back pain
[ ] Low back pain
[ ] Leg pain/ numbness/ tingling
[ ] Eyes sensitive to light
[ ] Pain behind the eyes
[ ] Weakness in arms / legs
[ ] Dizziness
[ ] Ringing in the ears
[ ] Loss of balance
[ ] Loss of memory
[ ] Fatigue
[ ] Irritability
[ ] Impaired concentration
[ ] Confusion
[ ] Throat pain
[ ] Painful swallowing
[ ] Poor sleep
[ ] Depression
[ ] Chest pain
[ ] Fainting
[ ] Blurry vision
[ ] Nausea
[ ] Vomiting
[ ] Jaw pain

WORK STATUS:

Occupation: ______________________ Employer: ____________________

How long have you been at your present job?_____________
Have you missed any work as a result of the accident? *YES or NO*
if *YES*, how long_____________

Have you been able to work since the accident? *YES or NO*

PAST HISTORY:

Have you ever had any injuries and/ or complaints similar to your current pain?___

If *YES*, where?____

When?___________________ Why?_________________________________

Have you ever been in a car accident before? *YES or NO* if YES, when?_______
Any injuries? ____

Are you currently being treated by another doctor for any other health conditions? *YES or NO* if *YES*, provide the doctor's names and condition___

____

Current medication____________________________________

SOCIAL HISTORY:

[ ] Smoke- packs/ day_____ , how long?_________ [ ] Alcohol

Exercise level: (circle one) Light Medium Heavy

Type of exercise________________________

FAMILY HISTORY:____

SURGICAL HISTORY:____

Primary care physician's name:_________________________________

PAIN DRAWING:

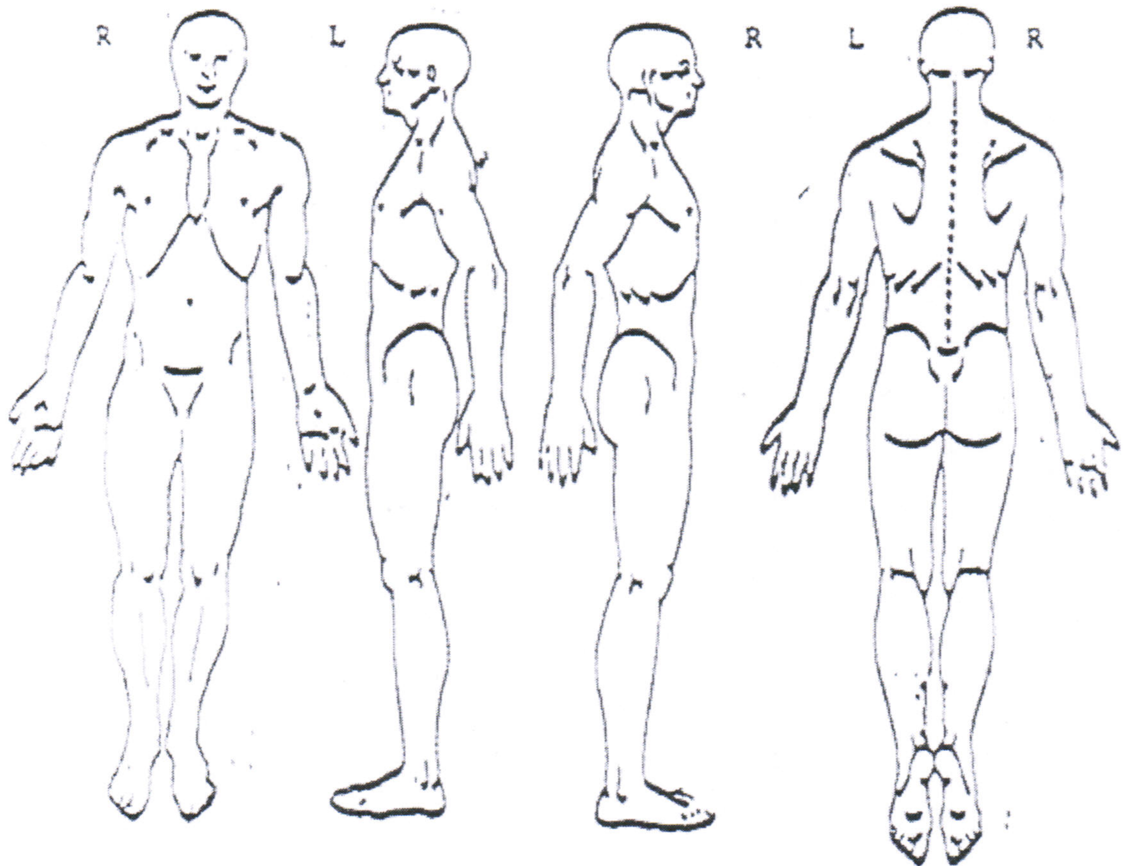
Circle the Severity of your pain on the line below:

0–1–2–3–4–5–6–7–8–9–10

(No pain) (Extreme pain)

Mark the location of your pain on the body outlines below using the following Letters:

A=Ache B=Burning N=Numbness P=Pins and Needles S=Stabbing X=Other(Specify)



I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. If my account is turned over to collection I agreed to pay any additional collection fees. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

NOTICE OF "HIPPA" PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. We strive to provide the best health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. You will be asked to authorize release of PHI to any party that is directly connected to your treatment, payment, or health care operations. If you have any questions, comments, or objections to the privacy policy on this form, please ask to speak with our compliance officer.

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Signature____ Date______________

Patient's Name______________________________ Number__________ Date______________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ 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 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.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- 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 one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – 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 at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments______________________________________

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name______________________________ Number____________ Date__________________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ 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.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ 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 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.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

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

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL______

Section 6 – Concentration

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

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments______________________________ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Spine Care of Alexandria, Inc.
6285 Franconia Rd.
Alexandria, VA 22310
Ph. 703-719-7302

Billing Agreement Personal Injury Claims

( ) I am choosing to pay cash, credit card or check for each visit at the time of service. I understand I am waiving my right to file my group medical insurance. I also understand that at the end of my treatment, Spine Care of Alexandria, Inc. is not responsible for providing any information to any other sources of insurance. I can request full copies of my medical records and billing at a cost of $25. for each copy provided.

( ) I am choosing to file my group medical insurance. I understand that I am fully responsible for any deductible, copay and or co-insurance at the time of service. I understand that I am responsible for balance left unpaid due to any maximums or non-covered services. I also understand that at the end of my treatment, Spine Care of Alexandria, Inc. is not responsible for providing any information to any other sources of insurance. I can request full copies of my medical records and billing at a cost of $25. for each copy provided

( ) I am choosing to file my personal automobile insurance. I understand I am waiving my right to file my group medical insurance. I understand that I am responsible for any balance left unpaid due to any maximums or non-covered services. I also understand that at the end of my treatment, Spine Care of Alexandria, Inc. is not responsible for providing any information to any other sources of insurance. I can request full copies of my medical records and billing at a cost of $25. for each copy provided

( ) Per Agreement of Spine Care of Alexandria, Inc. I have obtained and attorney and am agreeing to pay for my services out of my settlement with the other party. I understand I am waiving my right to file my group medical insurance. I have signed a lien/payment authorization to Spine Care of Alexandria, Inc. I understand that discounts will not be given in the event that settlement does not cover my total bill and that a payment plan can be worked out at that time.

____

Printed Name of Patient

__________________________________ ____________________

Signature of Patient Date

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between ______________________________("Patient") and **SPINE CARE ASSOCIATES OF ALEXANDRIA** ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it

may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice.

Acknowledged:______ (patient initials)

Witness the following signatures and seal as of the indicated date:

Patient

Patients Signature________________________________ Date _____________

Health Care Provider

Spine Care Associates of Alexandria

Printed Name: Philip Connolly D.C. Date____________

Signature: _____________________________________

Witness___________________________

Date_____________