Cle Elum chiropractic

Dawn Smallwood, DC, NTP

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MOTOR VEHICLE COLLISION HISTORY INFORMATION

Name:_____ Date:_____
(Last) (M.I.) (First)

Sex: ___M ___ F Marital status: (circle) single married divorced partnered widowed

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Please **Circle** best # to call

Email: _____

Occupation: _____ Employer: _____

Name of Spouse: _____ Referred by: _____

Emergency Contact: _____
(Name) (Phone) (Relationship to Patient)

HEALTH INFORMATION DISCLOSURE

I, _____, give permission to Cle Elum Chiropractic to disclose the following health information to _____:

_____ Scheduling Information
_____ Medical Information ***(Please initial any/all applicable categories)***
_____ Financial Information

I understand that this gives Cle Elum Chiropractic permission to disclose only the above-mentioned health information to only those above-mentioned individuals.

PARENT/LEGAL GUARDIAN AGREEMENT FOR MINORS

I, _____, am the individual who authorizes treatment and is responsible for the financial obligations of _____. I authorize treatment and agree to pay for all services provided to _____ here at Cle Elum Chiropractic.

Printed Name: _____

Signature: _____ Date: _____

Name: _____ Date: _____

AUTOMOBILE INSURANCE INFORMATION

Name of your automobile insurance carrier: _____

Have you reported this injury to your insurance carrier? YES NO

Claim #: _____

Claim Adjuster's Name and Phone #: _____
(Name) (Phone)

Do you have an insurance deductible? YES NO Deductible is: $_____

What is your policy limit for medical bills? _____

PATIENT COMPLIANCE INFORMATION

My initials and signature on this document indicates that:

1) I acknowledge that all the information I have given is accurate to the best of my knowledge and is necessary in order to receive the best possible care. I agree and take responsibility for notifying my practitioner if any physical or mental changes occur with my health (ie: injury, illness, pregnancy, etc) to ensure that the most appropriate and effective care continues to be given.

_____

2) I hereby acknowledge that I have read and fully understand the **NOTICE OF PRIVACY PRACTICES** outlining the policies and procedures concerning the privacy of my Patient Health Information and if there is anyone I do not want to receive my medical records, I have informed the office in writing. I agree to allow this office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations and not share my health information with anyone, unless I have signed a Records Release Form.

_____

3) I understand that it is **my responsibility to make it to all scheduled appointments and to notify the office or practitioner at least 24 hours in advance if a situation arises that leads to cancellation or rescheduling. I agree to pay the $50 missed appointment fee in the event I miss my appointment or cancel last minute.**

_____

4) I have read and fully understand this office's **FINANCIAL POLICIES** and know that I am ultimately responsible for any charges incurred at this office. I know that I am on an injury claim and if the claim closes or stops being paid by the insurance company, that I am responsible for payment, which is due at the time of service. I authorize the use of this signature on all insurance submissions.

_____

5) I give my permission and consent to the general procedure or treatment I will receive and know that if at any time I no longer wish to receive a specific treatment (or an aspect of), I have the right to inform my practitioner. I will ask my practitioner if have any questions concerning the general procedure.

_____

Signature: _____ Date: _____

Name: _____ Date: _____

MOTOR VEHICLE COLLISION FORM

Date of Injury: _____ Time of Injury: _____ AM PM

Street and City where collision occurred: _____ The street was: WET DRY SNOWY

What is the estimated damage to your vehicle? _____

Who owns the vehicle you were involved in: _____

Did the police come to the accident scene? YES NO
Did the police make a written report? YES NO
Were any photographs taken of your vehicle? YES NO If yes, who took these photos? _____

DESCRIBE HOW THE COLLISION HAPPENED

_____

_____

_____

_____

COLLISION DESCRIPTION TYPE

o Single-vehicle collision	o Side collision
o Rear-end collision	o Hit guard rail, tree, or object
o Head-on collision	o Three or more vehicles
o Two-vehicle collision	o Rollover
o Ran off the road	o Other (describe):

INDICATE YOUR SEATING POSITION

o Driver	o Left rear passenger
o Front passenger	o Right rear passenger

DESCRIBE THE VEHICLE YOU WERE IN: Model, Make, and Year_____

o Small-sized vehicle	o Mid-sized car	o Large-sized vehicle
o Pick-up truck	o Van	o Sport Utility Vehicle (SUV)
o 2-Door vehicle	o 4-Door vehicle	o Large truck, bus, or semi-truck
o Sedan	o Hatchback	o Stationwagon
o Other (describe):		

DESCRIBE THE OTHER VEHICLE: Model, Make, and Year_____

o Small passenger vehicle	o Mid-sized passenger vehicle	o Van
o Pick-up truck/Sports Utility Vehicle (SUV)	o Large-sized passenger vehicle	o Large truck, bus, or semi-truck

Name: _____ Date: _____

AT THE TIME OF IMPACT, YOUR VEHICLE WAS

o Slowing down	o Gaining speed
o Stopped	o Moving at steady speed

AT THE TIME OF IMPACT, THE OTHER VEHICLE WAS

o Slowing down	o Gaining speed	o Unknown
o Stopped	o Moving at steady pace	o Other:

DURING AND AFTER THE CRASH YOUR VEHICLE

o Kept going straight, not hitting anything	o Spun around, not hitting anything
o Kept going straight, hitting car in front	o Spun around, hitting another vehicle
o Was hit by another vehicle	o Spun around, hitting object other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING

Please draw lines from the body region on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other:

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR VEHICLE

o Windshield	o Seat frame	o Knee bolster
o Steering wheel	o Side-rear window	o Other:
o Dash	o Mirror	o Other:

ALL TYPES OF COLLISIONS

YES	NO	
o	o	Did any of the interior front or side structures, such as the side door, dashboard, steering wheel, or floorboard of your vehicle dent inward during the collision?
o	o	Did the side door touch your body during the collision?
o	o	Did your body slide under the seatbelt?
o	o	Was the door(s) of your vehicle damaged to the point where you could not open the door?
o	o	Did an airbag deploy in your vehicle during the collision? If yes, circle: SIDE FRONT
o	o	Were you under the influence of alcohol or drugs at the time of the collision?

Name: _____ Date: _____

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT

YES	NO	
o	o	Were you wearing a seatbelt?
o	o	Did you have any portion of your seatbelt positioned behind your chest, back, or shoulder?
o	o	Were you holding onto the steering wheel at the time of impact? If yes, circle where each hand was positioned. Left hand: Not on wheel Yes, hand at _____o'clock Hand elsewhere Right hand: Not on wheel Yes, hand at _____o'clock Hand elsewhere

REAR-END COLLISIONS ONLY

Describe your vehicle's head restraint system.

- o Movable/adjustable head restraint
- o No headrests in my vehicle
- o Fixed, non-moveable head restraint
- o Bench seat in your vehicle without head restraint

Please indicate how your head restraint was positioned at the time of collision.

- o At the top of the back of your head
- o Lower height of the back of your head
- o Level of your shoulder blades
- o Midway height of the back of your head
- o Located at the level of your neck

BRUISING AFTER THE COLLISION

Did your body have any bruising (areas that were visibly black and blue after the collision? YES NO

If yes, indicate where: _____

AWARENESS AND BODY POSITION DESCRIPTIONS (Check all that apply to you.)

- o You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
- o You were aware of the impending collision and relaxed before the collision.
- o You were aware of the impending collision and braced yourself.
- o Your body, torso, and head were facing straight ahead.
- o You had your head and/or torso turned at the time of collision: Turned to LEFT Turned to RIGHT
- o You were leaning forward at the time of impact resulting in a gap between your body and the seatback.
- o Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

How soon did you first notice any pain or soreness after the collision? _____

_____

Name: _____ Date: _____

POST TRAUMATIC SYMPTOM QUESTIONNAIRE

It is important for this section to be filled out in detail. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

+ = MILD ++ = MODERATE +++ = SEVERE

SYMPTOM LIST	Began in less than 24 HOURS after injury	Began 1 to 7 DAYS after injury	Symptoms you have currently	Similar symptoms 1 YEAR before this injury
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Ribcage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of legs				
Pain primarily in front of thighs				
Knee pain				
Ankle/foot pain				
Other:				

Name: _____ Date: _____

BEFORE AND AFTER INJURY PAIN COMPARISON CHART

PRIOR AND CURRENT PAIN INTENSITY LEVELS

First, ***SQUARE the box*** following the area of pain that best indicates your overall average, usual pain severity **BEFORE** this injury. Secondly, ***CIRCLE the box*** that indicates your **CURRENT** usual pain intensity.

PAIN INTENSITY	None	Minimal Discomfort/Ache/Stiff			Slight to Moderate Hurts/Sore/Bearable				Severe Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck discomfort	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Low Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:	0	1	2	3	4	5	6	7	8	9	10

PRIOR AND CURRENT PAIN FREQUENCY LEVELS

First, ***SQUARE the box*** following the area of pain that best indicates what average percentage of time you had pain **BEFORE** this injury. Secondly, ***CIRCLE the box*** that indicates your **CURRENT** typical pain frequency.

Pain Frequency	None	Occasional			Intermittent			Frequent		Constant	
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

HEADACHE AND/OR MIGRAINE FREQUENCY & DURATION

During the past week or since the collision/injury, if applicable (if less than one week) indicate how frequently you had headaches and/or migraines.

How frequently did you have headaches 2-3 months before this injury?	_____ x week, _____ x month
How frequently do you have headaches currently?	_____ x week, _____ x month
How many hours or days did a typical headache last before this injury?	_____ x week, _____ x month
How many hours or days do your typical headaches last currently?	_____ x week, _____ x month
How many headache pills did you take prior to the collision typically?	_____ x week, _____ x month
How many headache pills do you take currently since the collision?	_____ x week, _____ x month

Name: ____________________ Date: ____________

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Name Emergency Department/Hospital/Doctor/Therapist: ____________________

Address: ____________________ Date: ____________

Indicate what was done:

○ Exam-consultation	○ Acupuncture
○ X-rays	○ Anti-inflammatories
○ MRI/CT scan	○ Pain medications
○ EMG/nerve conduction study	○ Muscle relaxants
○ Rehabilitation	○ Exercises
○ Ultrasound	○ Injections
○ Spinal adjustments	○ Brace
○ Massage	○ Heat or Ice Packs
○ Physical therapy	○ Other:

Indicate if treatment with this provider: (circle one) Helped Did NOT help Made condition worse

Name Emergency Department/Hospital/Doctor/Therapist: ____________________

Address: ____________________ Date: ____________

Indicate what was done:

○ Exam-consultation	○ Acupuncture
○ X-rays	○ Anti-inflammatories
○ MRI/CT scan	○ Pain medications
○ EMG/nerve conduction study	○ Muscle relaxants
○ Rehabilitation	○ Exercises
○ Ultrasound	○ Injections
○ Spinal adjustments	○ Brace
○ Massage	○ Heat or Ice Packs
○ Physical therapy	○ Other:

Indicate if treatment with this provider: (circle one) Helped Did NOT help Made condition worse

Name Emergency Department/Hospital/Doctor/Therapist: ____________________

Address: ____________________ Date: ____________

Indicate what was done:

○ Exam-consultation	○ Acupuncture
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○ MRI/CT scan	○ Pain medications
○ EMG/nerve conduction study	○ Muscle relaxants
○ Rehabilitation	○ Exercises
○ Ultrasound	○ Injections
○ Spinal adjustments	○ Brace
○ Massage	○ Heat or Ice Packs
○ Physical therapy	○ Other:

Indicate if treatment with this provider: (circle one) Helped Did NOT help Made condition worse

Name: _____ Date: _____

NECK DISABILITY INDEX

Answer EACH of the 10 sections by marking only **ONE BOX IN EACH SECTION** for the statement that most applies to you.

PAIN INTENSITY

- o I have no pain at the moment.
- o The pain is very mild at the moment.
- o The pain is moderate at the moment.
- o The pain is fairly severe at the moment.
- o The pain is very severe at the moment.
- o The pain is the worst imaginable at the moment.

PERSONAL CARE

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

LIFTING

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

READING

- o I can read as much as I want with no neck pain.
- o I can read as much as I want with mild neck pain.
- o I can read as much as I want with moderate neck pain.
- o I cannot read as much as I want due to neck pain.
- o I can hardly read at all due to severe neck pain.
- o I cannot read at all due to severe neck pain.

HEADACHES

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

CONCENTRATION

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

WORK

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

DRIVING

- o I can drive my car without neck pain.
- o I can drive as long as I want with only slight neck pain.
- o I can drive as long as I want with moderate neck pain.
- o I cannot drive my car as long as I want because of neck pain.
- o I can hardly drive at all because of neck pain.
- o I cannot drive my car at all because of neck pain.

SLEEPING

- o I have no trouble sleeping.
- o My sleep is slightly disturbed by neck pain (<1 hour).
- o My sleep is moderately disturbed by neck pain (1-2 hours).
- o My sleep is moderately disturbed by neck pain (2-3 hours).
- o My sleep is greatly disturbed by neck pain (3-5 hours).
- o My sleep is completely disturbed by neck pain (>5 hours).

RECREATION

- o I am able to engage in all my recreational activities with no neck pain at all.
- o I am able to engage in all my recreational activities with some neck pain.
- o I am able to engage in most, but not all, of my usual rec activities because of neck pain.
- o I can hardly do any recreational activities because of neck pain.
- o I cannot do any recreational activities at all because of neck pain.

Name: _____ Date: _____

OSWESTRY LOW BACK PAIN SCALE

Answer EACH of the 10 sections by marking only **ONE BOX IN EACH SECTION** for the statement that most applies to you.

PAIN INTENSITY

- The 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 severe.
- The pain is severe and does not vary much.

PERSONAL CARE

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain, and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

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 off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. 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 only lift very light weights at the most.

WALKING

- I have no pain with walking.
- I have some pain with walking, but it does not increase with distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SITTING

- I can sit in any chair as long as I like.
- I can sit only 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 for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

STANDING

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SLEEPING

- I have no pain in bed.
- I have pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal nights sleep is reduced by less than ¼.
- Because of pain, my normal nights sleep is reduced by less than ½.
- Because of pain, my normal nights sleep is reduced by less than ¾.
- Pain prevents me from sleeping well.

SOCIAL LIFE

- My social life is normal and causes me no 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.
- 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 the pain.

TRAVELING

- I have no pain when traveling.
- I have some pain when traveling, but none of my usual forms of travel make it any worse.
- I have extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I have extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts me to short necessary travel.
- Pain restricts all forms of travel.

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.