Motor Vehicle Crash Information

Patient Name: _____ Today's date:_____
Date of Crash: _____ Time of Day: _____ ___ a.m. ___ p.m.

General Information:

Was there anyone else in the vehicle? yes no If yes, how many?____

In your own words please describe the accident:

_____
_____
_____
_____

List any parts of your body that made contact with the vehicle:

_____
_____

Did you go to the hospital? yes no If yes, how: ambulance drove other:__
If Yes, What treatment did you receive:_____
_____
_____
_____

Have you received treatment anywhere else? yes no If yes, please list dates and doctors names: _____
_____
_____

The vehicle you were traveling in:

Did your vehicle have seat belts? yes no
Were seat belts worn? yes no If yes, ___ shoulder ___ lap
Did the Vehicle have air bags? yes no If yes, did they work properly? yes no

Where were you sitting? driver's seat front passenger rear passenger (right/ left)
pedestrian other

Was there a headrest in the Vehicle? yes no
If there was a headrest in the vehicle how was the top of the headrest aligned?
With the top of your head With the middle of the head
With the bottom of your head

What was the make and model of the vehicle? _____

Where did the accident take place?

Street/ Highway Name: _____
Closest Intersection: _____ City_____ State _____

In which direction were you headed? (example: north, south, east, west, etc)_____
In which direction was the other vehicle headed? _____
What was the make and model of the other vehicle? _____
What was the weather condition? (clear, sunny, rainy, wet, foggy, etc.)_____

Was the collision: ___ head on ___ left side impact right side impact __ rear end
Were you braced for the collision? yes no
Were brakes applied? yes no
Were you looking: straight ahead right left __ rear view mirror
outside door mirror on the right left other:_____

Estimated speed of your vehicle: _____ Estimated speed of the other vehicle: _____

Were the Police contacted? yes no
If yes, was a report filed? yes no
Was a ticket issued? yes no
If yes, to whom was it issued to? _____

Have you been in any pervious Motor Vehicle Accidents? yes no If yes, please describe and give dates:
_____
_____

If yes, was treatment rendered previously? yes no If yes, please describe (give dates and doctor's names
_____
_____
_____

_____ _____ _____
Patient's Signature Date Guardian's Signature

BEACHSIDE CHIROPRACTIC
940 NORTH HALIFAX AVENUE
DAYTONA BEACH, FL 32118
PHONE: (386) 255-4338 FAX: (386) 248-1104

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Beachside Chiropractic, Inc. ("Assignee"), such sums as may be due and owing Assignee for the services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company is obligated to make payments to me upon charges made by the Assignee for its services refuses to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627 .4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

PATIENT _____ **DATE** _____

Application for Treatment
Beachside Chiropractic

I am interested in: __Temporary relief __ Long-term correction
__ Check here if you want the Doctor to select the care she feels is best for you.

Personal Information:

Name: _____ Age: _____ Today's Date:_____

Address: _____City: _____ST: ____ Zip_____

Social Security Number: _____ Home Phone: _____ Other Phone: _____

Sex: _____ Date of Birth: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Employer Name: _____

Employer Address: _____ Work Phone: _____

Name of Spouse: _____ E mployer of Spouse: _____

Name of Nearest Relative: _____ Phone: _____

Whom may we thank for referring you to our clinic? _____

Financial and Insurance Information:

Name of person responsible for payment: _____

Social Security Number: _____ Driver's License Number: _____

Do you have insurance? ___Yes ___No. If yes, Insurance company: _____

Policy Number: _____ Claim Number: _____ Patient Relationship: _____

Do you have other insurance? ___ Yes ___No Insurance company: _____

Policy Number: _____ Claim Number: _____ Patient Relationship:_____

How will the payment be made? __ Cash __ Check __ Credit Card __

I accept and understand that if accepted as a patient of the physician at Beachside Chiropractic I am authorizing them to proceed with any treatment necessary to me and /or my minor children. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

_____ _____

Patient's Signature Guardian's Signature

In case of an emergency, Contact? _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Ext._____

Patient Condition:

Reason for Visit: _____

Describe present Complaint:
_____
_____
_____

When did the symptoms appear?
_____

Is this condition getting progressively worse? __ Yes __ No __Unknown

At the time of this current complaint, were you under any medically prescribed disabilities or self imposed restrictions? __ Yes __ No If Yes, please describe:
_____

Does this interfere with: __ Work ___Sleep __ School __ Daily Routine __ Recreation

Present Complaints:

__ Headache
__Concentration loss
__Eyes sensitivity to light
__Memory Loss
__Heavy feeling of head
__Dizziness
__Ringing in ears
__Loss of balance
__Loss of smell
__Loss of taste
__Pain behind eyes
__Intolerance to Alcohol
__Fainting
__Palpitations
__Swelling: _____
__Nausea
__Constipation
__Diarrhea
__Digestive problems
__Vomiting

__Neck pain
__Neck stiffness
__Neck restriction of motion
__Upper back pain/stiff
__Mid back pain/stiff
__Low back pain/stiff
__Right/Left Hip pain
__Pain at sacrum
__Right/Left leg pain
__Pins & Needles arms/legs
__Right/Left shoulder pain
__Right/Left arm pain
__Lower back restricted motion
__Up/midback restricted motion
__Neuritis
__Cold hands
__Cold Feet
__Loss of consciousness
__Jaw pain
__Broken Bones:_____

__Vision Problems
__Sinus trouble
__Nervousness
__Chest pain
__Shortness of breath
__Irritable
__Numbness:_____
__Anxiety
__Depression
__Insomnia
__Fatigue
__Flushed face
__Excess perspiration
__ Flushed face
__Pale face
__Cuts:_____
__Bleeding:_____
__Bruises:_____
__Other:_____
__Other:_____

Other Medical Care:

List any/all doctors seen for this condition (include address):

_____

_____

Did you go to the hospital? __ Yes __No
If yes, how did you get there? __ Ambulance __Other: _____
If admitted to hospital, how long was your stay? _____
What kind of treatment did you receive? (X-rays, recommendations, etc.) _____
_____
_____

General Health History:

__AIDS/HIV	__Eating disorders	__Multiple Sclerosis
__Alcoholism	__Epilepsy	__Mumps
__Allergies: _____	__Fractures	__Osteoporosis
__Anemia	__Glaucoma	__Pacemaker
__Appendicitis	__Gonorrhea	__Parkinson's Disease
__Arthritis	__Headaches	__Pinched Nerve
__Asthma	__Heart Disease	__Pneumonia
__Bleeding Disorders	__Hepatitis	__Polio
__Breast Lump	__Hernia	__Prostate Disorders
__Bronchitis	__Herpes	__Psychiatric Care
__Cancer	__High Cholesterol	__Rheumatoid Arthritis
__Cataract	__High Blood Pressure	__Stroke
__Chemical Dependency	__Kidney Disease	__Thyroid Problems
__Diabetes	__Liver Problem/Disorder	__Tuberculosis
__Digestive Problems	__Lung Problem/Disorder	__Vaginal Infections
__Dizziness	__Migraines	__Venereal Disease
__Digestive Problems	__Miscarriages	__Other: _____
__Disc Herniation	__Mononucleosis	__Other:_____

__Other:_____

Any Prior Hospitalizations or Surgeries? __ Yes __No
If Yes, Please
list:_____

_____

_____

Females Only:
Are you pregnant? __ Yes __ No When was the onset of your last menses? _____
If you think you may be pregnant please check here__ (X-rays can be harmful to the unborn child.) Have you experienced/experiencing menopause? __ Yes __ No

Pre- Existing Conditions:

Have you sought care for a health condition in the past year? __ Yes __ No
Have you sought care for a health condition in the past two years? __ Yes __ No
If yes, what condition(s)? _____

_____

_____

Was treatment given? __ Yes __ No If yes, please describe:_____

_____

Do you take prescription or over the counter medication? __ Yes __ No
If yes, please list: _____

_____

Have you broken any bones? __ Yes __ No If yes, please list:_____

_____

Do you have any allergies? __ Yes __ No If yes, please list:_____

_____

Accident Information:

Is this office visit due to an accident? __ Yes __ No
Type of accident: __ Auto __Work Related __ Home __ Sports __ Other
Date of Accident/ Injury: _____ Time:_____

Briefly describe the accident/ Injury: _____

_____

_____

_____

To whom have you reported this injury:
__ Auto Insurance __ Health Insurance __ Attorney __ Employer __Workers Comp.

Other: _____

Attorney Name if applicable: _____phone: _____

3.7 Appendixes

Appendix 3-1 Pain Disability Questionnaire

Patient Name: _____ **Date:** _____

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — *Unable to work at all*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — *Need help with all my personal care*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

3. Does your pain interfere with your traveling?
   Travel anywhere I like — *Only travel to see doctors*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

4. Does your pain affect your ability to sit or stand?
   No problems — *Cannot sit / stand at all*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — *Cannot do at all*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — *Cannot do at all*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

7. Does your pain affect your ability to walk or run?
   No problems — *Cannot walk / run at all*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

8. Has your income declined since your pain began?
   No decline — *Lost all income*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

9. Do you have to take pain medication every day to control your pain?
   No medication needed — *On pain medication throughout the day*
   0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — *See doctors weekly*
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem — *Never see them*
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference — *Total interference*
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — *Need help all the time*
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression / tension — *Severe depression / tension*
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities?
    No problems — *Severe problems*
    0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

_____
Examiner

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.