PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Patient Name:	Today's Date:
Date of Birth:	Height: Weight:
Date of Accident:	Time of Accident:

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

AUTOMOBILE INSURANCE INFORMATION

Idaho is a no-fault state. The insurance information you give us must be your auto insurance carrier and claim number if you have medical coverage. Your insurance company will setlle with the party at fault once treatment is complete. This will not raise your auto insurance rates.

Do you or someone else have insurance coverage for the vehicle you were in?	I have, Someone else has coverage. Indicate name of person policy is under:
How is this person related to you?	Self, Parent, Friend, Other
Name of your Automobile Insurance Carrier:	
Claim Adjuster's Name:	
Claim Adjuster's Telephone Number:	
Claim Number:	
Do you have an Insurance Deductible?	Yes, No Deductible is $
Do you know your Policy Limits for medical bills?	Yes, No Limit is $
Have you reported this injury to your insurance carrier?	Yes, No

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.* **Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.**

It is essential that if your insurance carrier sed you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Do you have an attorney representing you?	Attorney Name:
	Address:
Yes, No If yes, indicate name and address:	Telephone:

Signature of responsible party (Patient or Parent)_____ Date_____

MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name: _____ Date: _____
Date of injury: _____ Time of injury _____ AM PM
City where crash occurred: _____ Was the street wet or dry? Wet Dry
Street (location) where crash occurred: _____
What is the estimated damage to your vehicle? $_____
Who made damage estimates on your vehicle? _____
Who owns the vehicle you were involved in: _____
Yes, No Did the police come to the accident scene and make a report?
Yes, No Were you cited by the police? If yes, name of officer: _____

DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of car crash were you involved in:

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

INDICATE YOUR SEATING POSITION

	Driver		Front passenger		Left rear passenger		Right rear passenger

DESCRIBE THE VEHICLE YOU WERE IN:

Model, Make, and Year:

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

DESCRIBE THE OTHER VEHICLE:

Model, Make, and Year: Unknown

	Small car		Mid-sized car		Van
	Pick-up truck/sports utility		Full-sized car		Large truck, bus, or semi-truck

MOTOR VEHICLE CRASH FORM (Page 2)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

	Slowing down		Gaining speed
	Stopped		Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

	Slowing down		Gaining Speed		Unknown speed
	Stopped		Moving at steady speed		Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

	Kept going straight, not hitting anything		Spun around, not hitting anything
	Kept going straight, hitting car in front		Spun around, hitting another car
	Was hit by another vehicle		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 regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield
Face	Side window
Shoulder	Side door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt
Hip/abdomen	Frame of car near windows
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

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

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

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES	NO	
		Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
		Did the side door touch your body during the crash?
		Did your body slide under the seatbelt?
		Was the door(s) of your vehicle damaged to point where you could not open the door?
		Did an airbag deploy in your vehicle during the crash?
		Were you intoxicated (alcohol) at the time of crash?

MOTOR VEHICLE CRASH FORM (Page 3)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES	NO	
		Were you wearing a seatbelt? If yes, does your seatbelt have a: Lap and Shoulder Strap, Lap belt only
		Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
		Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned (Use time clock face as your reference point) 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 Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

Movable/adjustable head restraint — Fixed, non-moveable head restraint

No headrests in my vehicle — Bench seat in your vehicle without head restraint

Please indicate how your <u>head restraint</u> was positioned at the time of crash (if present):

At the top of the back of your head — Midway height of the back of your head

Lower height of the back of your head — Located at the level of your neck

Level of your shoulder blades

OTHER FACTORS

YES	NO	
		Did your body (chest, breast, knee face, head) hit the roof of your vehicle, hit the steering wheel, dash, or other structures within your vehicle. If yes, indicate what happened: _____
		Did your car separate away from the striking vehicle after the crash? If yes, you are indicating that after the crash your car was pushed away from the striking vehicle and your vehicle did not stay attached. If yes, indicate your estimate of the distance between vehicles after the crash: _____ feet.

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all areas that apply to you.

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

WHAT HAPPENED AFTER THE CAR CRASH?

EMERGENCY ROOM

YES	NO	
☐	☐	Did you go to the emergency room afterward? If yes, date/time: _____ What is name of the emergency room?
☐	☐	Did you go to emergency room in an ambulance? If yes, Name of ambulance:
☐	☐	Did you or another person drive you to emergency room?
☐	☐	Were you hospitalized after the accident? If yes, how many days?
☐	☐	Did emergency room doctor take X-rays? Check what was taken ☐ Skull ☐ Ribs/Chest ☐ Neck ☐ Collar bone ☐ Low back ☐ Shoulder ☐ Shoulder or arm ☐ Leg
☐	☐	Did the emergency room doctor give you pain medications?
☐	☐	Did the emergency room doctor give you muscle relaxants?
☐	☐	Did you have any broken bones or fractures? If yes, where:
☐	☐	Did you have any dislocations? If yes, where:
☐	☐	Did you have any bruises or lumps? If yes, where:
☐	☐	Did you have any cuts or lacerations?
☐	☐	Did you require any stitching for cuts?
☐	☐	Were you given a neck collar or back brace to wear?
☐	☐	Did you require surgery after the accident? Date and type:

WHEN DID YOU FIRST NOTICE ANY PAIN AFTER INJURY?

☐	Immediately	☐	_____ Hours after injury	☐	_____ Days after injury

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME WITHIN THE FIRST WEEK, INDICATE WHY (Check all that apply only if you had delay in seeing doctor)

☐	No pain was noticed	☐	No appointment schedule available
☐	No transportation	☐	Work/home schedule conflicts

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME WITHIN THE FIRST MONTH AFTER INJURY, INDICATE WHY? (Check all that apply)

☐	No pain was noticed	☐	No appointment schedule available
☐	No transportation	☐	Work/home schedule conflicts
☐	I thought pain would go away	☐	Other

HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ YES, ☐ NO If yes, you were off work: ☐ Partially or ☐ Completely

Please list all dates off work: From _____ to _____.

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at each symptom listed below and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Leave the row blank if the symptom listed does not apply to you.

SYMPTOM LIST	FELT RIGHT AFTER INJURY	BEGAN ½ TO 7 DAYS LATER	HAVE SYMPTOMS CURRENTLY	HAD SIMILAR SYMPTOMS 1-3 MONTHS 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				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain				
Rib cage pain				
Low back pain/soreness				
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				

SYMPTOM QUESTIONNAIRE (Page 3)

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following body movements that intensify your low back pain or leg symptoms:

☐	Sitting	☐	Bending forwards	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backwards	☐	Lying on your back	☐	Putting on shoes

Check all locations of any current leg pain, numbness, or tingling:

☐	Hip	☐	Buttock	☐	Back of thigh	☐	Calf
☐	Groin area	☐	Knee	☐	Front of thigh	☐	Foot/toes

YES	NO	Check all areas with a yes or no please
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your low back pain or leg pain get worse recently?
☐	☐	Do you have a consistent pattern of getting severe leg pain after walking for similar distances that is relieved by resting or sitting down. This pain resumes after walking for same distance again. *
☐	☐	Do you get leg cramping while walking that is relieved by resting, leaning against an object, or sitting. This pain is worse at night time and is relieved by walking around for a couple of minutes. **
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down. This pain doesn't bother you at night time or while sitting. **
☐	☐	Does your leg or foot drag on the floor recently?
☐	☐	Do you get a lot of leg cramps at night time recently?
☐	☐	Have you had any urinary or bowel incontinence recently or had difficulty urinating or having bowel movements during the same time as your having low back pain or leg pain?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you observed that your low back pain is not relieved by any type of postural change?
☐	☐	Do your feet feel cold recently? If yes, indicate which feet:
☐	☐	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
☐	☐	Have you ever had an injection of Chymopapain into your discs in your back or neck?
☐	☐	Have you recently noticed that either of your legs occasionally give out on you when you walk? ***
☐	☐	Does one or both of your legs feel weak recently?
☐	☐	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
☐	☐	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
☐	☐	If you have radiating leg or foot pain did you notice low back pain or soreness before your leg symptoms became noticeable?
☐	☐	If you have leg pain, is your leg pain primarily focused in front of your thigh(s)?
☐	☐	Has your anal-rectal region been completely numb recently?
☐	☐	**Men Only. Do you have any recent prostate or urinary problems?**
☐	☐	**Women Only. Do you have any recent ovarian, uterine, or bladder problems?**

* R/O Claudication, ** R/O Vascular/Neuro Stenosis, *** R/O Sacroiliac involvement, R/O = Rule Out

SLEEPING PATTERNS

YES	NO	
☐	☐	Do you sleep poorly at night recently?
☐	☐	Do you sleep on your stomach?
☐	☐	Do you consistently feel extremely tired when you wake up in the morning recently?

Form 1403

PAST AND PRESENT GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or currently have:

YES	GENERAL QUESTIONS	YEAR
☐	I bruise easily currently	N/A
☐	I heal slowly currently	N/A
☐	My body temperature is normally low (feel cold) recently *	N/A
☐	Smoke cigarettes currently or in the past	N/A
☐	Diabetic	
☐	Heart Attack history (recent and old)	
☐	Epilepsy-Seizure history	
☐	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	
☐	Cancer history or treatment of any type	
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	
☐	Told that you have scoliosis, spondylolisthesis, disc degeneration, or a herniated disc	
☐	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	
☐	Rheumatoid arthritis	
☐	Thyroid disorders	
☐	Coma from head injury or other problem	
☐	Told you have osteoporosis of your spine	
☐	Told you have osteoarthritis of your spine or hip joints	
☐	**Women only: Check this box if you currently have any type of breast implants**	**N/A**
☐	**Women only: Check this box if there any chance that you are currently pregnant**	**N/A**

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(☐ **I have no history of previous painful injury or pain**) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car accident
☐ Motorcycle Injury	☐ Bicycle Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain or Arm Pain	☐ Middle Back Pain	☐ Low Back/Leg Pain	☐ Other Pain

FRACTURES/BROKEN BONES

(☐ **I have never had any broken bones**). If you have broken any bones, indicate where and when:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis bone		☐ Other	

PREVIOUS SURGERIES

(☐ **I have never had any surgical procedure**). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck or back)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other	

* R/O Thyroid

IRREVOCABLE ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO **IDAHO CHIROPRACTIC GROUP, PLLC**

1. In consideration for the professional services provided by Idaho Chiropractic Group, PLLC, I, _____, do hereby irrevocably assign to Idaho Chiropractic Group, PLLC any and all right and interest I may have to insurance proceeds, settlement proceeds or both up to the full amount of the outstanding balance of the charges incurred for services provided by Idaho Chiropractic Group, PLLC relating to my injury of _____. My insurance company is _____.

2. I do hereby further instruct my attorney and/or responsible insurance company to make said payment directly to Idaho Chiropractic Group, PLLC. My attorney is

   _____.

3. This assignment of my rights and interests is irrevocable and continuous.

4. A photocopy of this assignment shall be considered as effective and valid as the original.

Dated this _____day of _____, 200__.

_____

Sign Name

_____

Print Patient's Full Name

Date:_____

I, _____,
acknowledge that I have received a copy of the irrevocable Assignment I executed in favor of Idaho Chiropractic Group, PLLC.

_____

Sign Name

_____

Print Patient's Full Name

IDAHO CHIROPRACTIC GROUP

EXPECT RESULTS

403 S. 11th Street, Suite #110
Boise, ID 83702
208/343-6900
Fax 208/343-0642

To: All Auto Accident/Personal Injury Patients

Please note that when your insurance company, the third party insurance company, and/or your attorney wish for you to settle your claim, *please call to check on the status and amount owed on your account with us first.*

Insurance companies, when wishing to settle your claims, may not have paid all outstanding billings. In such cases, after your settlement with them, you will be responsible for all outstanding bills not paid by them by the time of your settlement.

We will be sending periodic statements to you while you are treating with us. Upon release, you will be given a final billing noting all outstanding bills. However, payments may be made on such accounts, so for accurate information, you will need to call.

Third Party Billing: If the doctor agrees to bill third party claims, the patient will be responsible for making monthly payments on their account until such account is settled. The amount of the monthly payment will depend on the estimated treatment plan frequency and duration and will be given at the second visit.

Maxed Medical Limits: If your medical limit under *your* auto insurance has been met, you will be responsible for making monthly payments until your account is settled. You may ask us to submit to your private health insurance carrier for unpaid charges. However, you will still be required to make monthly payments, the amount of which will be determined by charges outstanding.

Should you have questions either during or after your treatment, please feel free to give us a call at any time.

Thank you for your patronage and we look forward to treating you.

I have read and understand the billing policy for auto accident/personal injury claims:

Patient Signature:_____ **Date:**_____

Timothy J. Klena, DC, DABCO
Chiropractic Orthopedist

Corey D. Matthews, DC, FIAMA
Chiropractic Physician & Acupuncturist

A Downtown Boise Chiropractic Clinic Offering:

Orthopedic & Neurological Exams **Chiropractic Adjustments** **X-ray Analysis** **Orthotics**
Acupuncture **Muscle Therapy** **Ultrasound** **Electric Stimulation**
Therapeutic Stretching **Mechanical Traction** **Exercise Rehab** **Nutritional Programs**