PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Today's Date: _____

Last Name: **MI:** **First Name:**	
Home Address: **City:** **State:** **Zip:**	
Date Birth: Age:	Social Security No:
Height: Weight:	Drivers License No:
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:	Name of Family Physician:
Email:	

☐ **YES,** ☐ **NO I authorize the following telephone numbers:** ☐ **YES,** ☐ **NO I authorize the use of my name/address** Home: _____Work _____ Cell: _____ Pager: _____ Indicate if you have a preferred mailing address: _____ _____ Signature: _____Date:_____ Expiration Date/Event for Authorization: ☐ No expiration date ☐When I have discontinued treatment and all bills have been paid. ☐ Date:	Dr Dhesi, 1081 Market Place, Suite 100, San Ramon, CA 94583, needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate the name of the person that the policy is under:
How is this person related to you?	☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: Telephone (area code):
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

☐ Yes, ☐ No. Do you have an attorney representing you? If yes, indicate name, address and telephone of your retained attorney:	Attorney Name: _____ Address: _____ Telephone:

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.

Patient Signature Date	I am ultimately responsible for all charges that are incurred at the doctor's office. I agree to pay for any outstanding bills incurred in this office, as well as paying for co-insurance or deductibles.

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

GENERAL HEALTH HISTORY

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

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	☐	☐
☐	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	History of any disease such as AIDS, Tuberculosis, Meningitis, etc.?	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	☐	☐
☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	☐	☐
☐	Cancer history or cancer treatment of any type?	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)?	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?	☐	☐
☐	Have you ever been hospitalized? Why/When:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	☐	☐
☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	☐	☐
☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY AND/OR PREVIOUS PAIN (☐ I have never had any injuries or pain) If yes, check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ arm numb/tingling	☐ Arm Pain	☐ Leg Pain/Tingling	☐ Other Pain:	

Describe:

FRACTURES/BROKEN BONES HISTORY

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

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib(s) or sternum chest bone	
☐ Arm or hand bones		☐ Leg or foot bones	
☐ Pelvis or hip bones		☐ Other: List	

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, back, or pelvis)		☐ Abdominal/chest Surgery or Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Liver/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain/Spinal Cord/Nerve		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

GENERAL HEALTH HISTORY (Page 2)

☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe:____
_____

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City : _____ Year:_____
List Problem(s) that the Chiropractor treated you for:_____

☐ No, ☐ Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Since the injury did your pain and other symptoms come on? ☐ Suddenly, ☐ Gradually

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

SYMPTOM QUESTIONNAIRE (Page 3)

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

NECK REGION

YES	NO	
☐	☐	Does neck and head movement cause your neck pain to intensify?
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
☐	☐	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____min/hrs)
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders?
☐	☐	Do you feel your neck pain sending pain downwards to the front of your chest?
☐	☐	Have you noticed your head leaning or tilting to one side recently?
☐	☐	Have you ever been diagnosed as having a disc bulge or disc herniation in your neck?

ARM, HAND, OR FINGER REGION

YES	NO	
☐	☐	Do you have pain, numbness, or tingling in your shoulder, elbow, forearm, or hand? Circle areas
☐	☐	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
☐	☐	Do you get increased arm numbness when lying flat on your back or sleeping on your side?
☐	☐	Does changing your sitting posture increase your arm/hand symptom intensity?
☐	☐	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
☐	☐	If you have arm symptoms, do they improve when you lift your arms over your head?
☐	☐	If you have arm symptoms, do they worsen when you lift your arms over your head?
☐	☐	If you have hand or arm pain at night, does it help to shake and massage them?
☐	☐	Do your hands feel tender when you grasp objects?
☐	☐	Do you feel weakness in your grip strength?
☐	☐	Do you drop objects from your hand?
☐	☐	Do you have difficulty writing or doing small motions with your fingers recently?
☐	☐	Do your hand(s) or wrist swell?
☐	☐	Do your hands burn?
☐	☐	Are your fingers or hands frequently cold?
☐	☐	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?

MIDDLE BACK AND CHEST WALL REGION

YES	NO	
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
☐	☐	When you move your neck around, does your middle back pain or chest pain increase?
☐	☐	Have you been diagnosed as having angina before?
☐	☐	Do you have a tight band-like feeling sometimes around your chest?
☐	☐	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	Does your middle back pain mostly bother you during sleep?

SYMPTOM QUESTIONNAIRE (Page 4)

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following that intensify your low back pain and/or leg symptoms:

☐	Sitting	☐	Bending forward	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backward	☐	Lying on your back	☐	Putting on shoes

Check any of the following that lessen/improve your low back pain and/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 (Skip if you are unclear about question)***
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
☐	☐	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 or while sitting.
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Do you have a lot of leg cramps at night recently?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you observed that your low back pain is not relieved or made worse by any type of postural change?
☐	☐	Do your feet feel cold recently? If yes, indicate which foot or if both 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 (Spine) in your back or neck?
☐	☐	Have you recently noticed that either of your legs occasionally gives 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 your leg symptoms before the low back pain started?
☐	☐	If you have leg pain, is your pain primarily focused in front of your thigh(s)?
☐	☐	Has your anal-rectal region been completely numb?
☐	☐	Do you have any recent prostate, ovarian, or uterine problems?
☐	☐	Have you ever had abdominal surgery, chest surgery, reconstructive surgery or other conditions in your past where your doctor has recommended that you should be careful when twisting or lifting?
☐	☐	Other:

SLEEPING PATTERNS

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

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. 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.*

SYMPTOM LIST **(Check all that apply to you)**	**BEGAN IN LESS THAN 24 HOURS AFTER INJURY**	**BEGAN 1 TO 7 DAYS AFTER INJURY**	**YOU HAVE SYMPTOMS PRESENTLY**	**HAD SIMILAR SYMPTOMS WITHIN 12-MONTHS PRIOR TO THE INJURY**
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Nausea or vomiting				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other				

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name:_____ Date: _____
Date of crash:_____ Time of collision: _____ ☐ AM ☐ PM
City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry
Street (location) where crash occurred: _____
Who owns the vehicle in which you were hit? _____
What is the estimated repair damage to your vehicle? $_____ ☐ Unknown, ☐ Estimate not done yet
How many people were in your vehicle at the time of the crash? _____
☐ Yes, ☐ No Did the police come to the crash scene?
☐ Yes, ☐ No Did the police make a written report?
☐ Yes, ☐ No Were any photographs taken of the vehicles? If yes, who took them?

DESCRIBE HOW THE CRASH HAPPENED

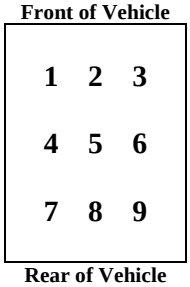
_____
_____
_____
_____

COLLISION DESCRIPTION-TYPE

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

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

CIRCLE YOUR SEATING POSITION (The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.



DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

Doctor's Name/Address: Sarbjit Dhesi, DC, 1081 Market Place, Suite 100, San Ramon, CA 94583

MOTOR VEHICLE CRASH FORM (Page 2)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

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

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/curb 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 or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE COLLISION:

☐	Windshield	☐	Seat bent or damaged	☐	Dash or area around knee/foot
☐	Steering wheel	☐	Side or rear window broken	☐	Other
Describe Damage:					

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES	NO	
☐	☐	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
☐	☐	Did you strike or did any objects or animals within your vehicle hit you during the crash?
☐	☐	Was the door(s) of your vehicle damaged to a point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes, circle (side airbag/front airbag)
☐	☐	Did you have any cuts, bruises, or abrasions from the airbag deploying?
☐	☐	Did your seatbelt system require repairs after the crash?
☐	☐	Was the back of your seat that your were sitting in damaged or bent during the crash?
☐	☐	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

Patient Name:	Doctor's Name: Sarbjit Dhesi, D.C.

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, ☐ Automatic shoulder strap with driver needing to manually attach lap belt, ☐ Lap belt only
☐	☐	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
☐	☐	Did you have any cuts, bruises, or abrasions from the seatbelts?
☐	☐	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

BRUISING AFTER THE CRASH?

YES	NO	
☐	☐	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising (if known):

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 turned/what were you doing?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU *FIRST* NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

_____

MOTORCYCLE COLLISION

PATIENT INFORMATION

Patient Name:_____
Address: _____ City _____ Zip _____
Home Telephone: _____ Work Telephone: _____
Date of Birth: _____ Social Security No: _____
Date of injury:_____ Time of injury: _____ ☐ AM ☐ PM
City where crash occurred: _____
Street (location) where crash occurred: _____
What is the estimated damage to your motorcycle? $_____
Name of company/person giving damage estimate:_____
☐ Yes, ☐ No Did the police come to the collision scene and make a report?
☐ Yes, ☐ No Were you cited by the police? If yes, name of officer: _____
☐ Yes, ☐ No Is an attorney currently representing you? Name/address/phone: _____

DESCRIBE HOW THE MOTORCYCLE CRASH HAPPENED:

_____
_____
_____

COLLISION DESCRIPTION

Check all that apply to you. Were you involved in the following type of collision event:

☐ Single-motorcycle crash	☐ Two-motorcycles in crash	☐ Three-or-more vehicles
☐ Motorcycle-to-car crash	☐ Lost control	☐ Ran off road
☐ Motorcycle-to-truck crash	☐ Hit guardrail/tree/object	☐ Other

YOU WERE THE:

☐ Driver ☐ Rear passenger

OTHER PERSON ON MOTORCYCLE:

☐ Yes ☐ No Was there another person riding on the motorcycle? If yes, Name:

DESCRIBE THE MOTORCYCLE YOU WERE ON:

Model Year/Make and if modified:

HELMET USE

☐ Yes ☐ No Were you wearing a motorcycle helmet at the time of the crash?
☐ Yes ☐ No If yes, did your helmet break or crack?
☐ Yes ☐ No If you were wearing a helmet was it a full faced helmet? (Includes chin and face)

Doctor's Name/Address:

MOTORCYCLE COLLISION (Page 2)

DESCRIBE THE OTHER VEHICLE/OBJECT THAT YOUR MOTORCYCLE HIT:

☐ Small car	☐ Mid-sized car	☐ Full-sized car
☐ Pick-up truck/Sport utility vehicle	☐ Large truck	☐ Large bus or Semi-truck
☐ Motorcycle	☐ Pedestrian	☐ Other

AT THE TIME OF IMPACT YOUR MOTORCYCLE WAS:

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

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐ Slowing down	☐ Gaining Speed
☐ Stopped	☐ Moving at steady speed

DURING AND AFTER THE CRASH, YOUR MOTORCYCLE:

☐	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 second or third vehicle	☐	Spun around, hitting object other than car
☐	Flipped end-over-end	☐	Other

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match the left side to the right side.

Head	Front Windshield
Face	Side window
Shoulder	Side door or side of car
Arm/hand	Front grill of vehicle
Front chest wall	Hood of car
Side chest wall	Pavement/Street Surface
Hip/abdomen	Frame of car near windows
Knee	Roof of other vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS BROKE, BENT, OR WERE DAMAGED ON YOUR MOTORCYCLE

☐ Front wheel	☐ Seat frame	☐ Faring
☐ Handle bars	☐ Motor	☐ Other
☐ Front forks	☐ Rear wheel	☐ Other

Patient Name:	Doctor's Name:

BICYCLE COLLISION EVENT

PATIENT INFORMATION

Patient Name:_____ Date: _____
Address: _____ City _____ Zip _____
Home Telephone: _____ Work Telephone: _____
Date of Birth: _____ Social Security No: _____
Date of injury:_____ Time of injury: _____ ☐ AM ☐ PM
City where crash occurred: _____
Street (location) where crash occurred: _____
Describe the damage to your bicycle? _____
What were the repair costs for the bicycle?_____
☐ Yes, ☐ No Did the police come to the collision scene and make a report?
☐ Yes, ☐ No Were you cited by the police? If yes, name of officer: _____
☐ Yes, ☐ No Is an attorney currently representing you?
If yes, indicate attorney name/address/phone:

DESCRIBE HOW THE BICYCLE CRASH HAPPENED:

_____
_____
_____

ACCIDENT DESCRIPTION (Check all that apply to you)

☐ Single-bicycle crash	☐ Hit object	☐ Hit person
☐ Bicycle-to-car/truck crash	☐ Hit or attacked by dog	☐ Other

HELMET USE

☐ Yes ☐ No Were you wearing a bicycle helmet?
☐ Yes ☐ No Did your helmet break?

AT THE TIME OF IMPACT YOUR BICYCLE WAS:

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

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐ Slowing down	☐ Gaining Speed
☐ Stopped	☐ Moving at steady speed

Doctor's Name/Address:

BICYCLE ACCIDENT (Page 2)

DURING AND AFTER THE CRASH, YOUR BICYCLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, falling down	☐	Spun around, hitting another car
☐	Was hit by a second vehicle	☐	Spun around, hitting object other than car
☐	Flipped end over end	☐	Other

CHECK IF ANY OF THE FOLLOWING PARTS BROKE, BENT, OR WERE DAMAGED ON YOUR BICYCLE

☐	Front wheel	☐	Seat frame	☐	Frame
☐	Rear wheel	☐	Handle bars	☐	Other

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match the left side to the right side.

Head	Front Windshield
Face	Side window
Shoulder	Side door or side of car
Arm/hand	Front grill of vehicle
Front chest wall	Hood of car
Side chest wall	Pavement/Street Surface
Hip/abdomen	Frame of car near windows
Knee	Roof of other vehicle
Leg	Another occupant/animal
Foot	Other

DOG ATTACK

☐ Yes ☐ No Was the dog on a leash?

If attacked by a dog, indicate areas of body bitten and if any of your clothing was damaged.

(Doctor's Name, Address, Telephone)

PEDESTRIAN COLLISION EVENT

PATIENT INFORMATION

Patient Name: _____Date: _____
Address: _____ City _____ Zip _____
Home Telephone: _____ Work Telephone: _____
Date of Birth: _____ Social Security No: _____
Date of injury:_____ Time of injury: _____ ☐ AM ☐ PM
City where pedestrian injury occurred: _____
Street (location) where injury occurred: _____

☐ Yes, ☐ No Did the police come to the collision scene and make a report?
☐ Yes, ☐ No Were you cited by the police? If yes, name of officer: _____
☐ Yes, ☐ No Is an attorney currently representing you? Name/address/phone: _____

PEDESTRIAN INJURY DESCRIPTION

DESCRIBE HOW THE PEDESTRIAN INJURY HAPPENED:

_____
_____
_____

INDICATE (CHECK) STREET/CROSSWALK ENVIRONMENT YOU WERE IN:

☐	In marked crosswalk with stop signs
☐	In marked crosswalk with lighted pedestrian signs
☐	In unmarked area of the street. Injury did not occur in marked crosswalk area
☐	Other

AT THE TIME OF IMPACT YOU WERE:

☐ Walking	☐ Running/Jogging
☐ Stopped	☐ Other

DESCRIPTION OF VEHICLE THAT HIT YOU:

☐ Passenger car	☐ Motorcycle	☐ Bus
☐ Sports Utility Vehicle	☐ Bicycle	☐ Semi-truck
☐ Pick-up Truck	☐ Large truck	☐ Other

POSTED SPEED LIMIT IN IMPACT AREA (If uncertain check the unknown box):

WHAT IS THE SPEED LIMIT POSTED IN THE AREA WHERE THE INJURY OCCURRED?
_____ MPH. ☐ Unknown

Doctor's Name/Address:

PEDESTRIAN COLLISION (Page 2)

AT THE TIME OF IMPACT THE VEHICLE THAT HIT YOU WAS:

☐	Slowing down	☐	Gaining Speed
☐	Braking. You heard the brakes.	☐	Moving at steady speed

DURING AND AFTER THE IMPACT, DID YOUR BODY:

☐	Stay upright, not falling down	☐	Flip upwards onto the hood or roof of the car
☐	Fall down hitting street or sidewalk	☐	Slide along street or sidewalk
☐	Got hit by another vehicle	☐	Slide under the striking vehicle
☐	Flip end-over-end in front of the vehicle	☐	Other

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match the left side to the right side.

Head	Front Windshield
Face	Front Bumper
Shoulder	Light Fixtures
Arm/hand	Front grill of vehicle
Front chest wall	Hood of car
Side chest wall	Pavement/Street Surface
Hip/abdomen	Frame of car near windows
Knee	Roof of other vehicle
Leg	Other
Foot	Other

CHECK IF ANY OF THE PARTS BROKE, BENT, OR WERE DAMAGED IN THE VEHICLE THAT HIT YOU:

☐	Front Bumper	☐	Front Windshield
☐	Front Hood	☐	Roof of vehicle
☐	Front Grill	☐	Unknown

* If your body was thrown or slid after the impact, estimate how many feet you slid or were thrown?
_____ feet. **If unknown, write in "unknown."**

Patient Name:	Doctor's Name/Address

SLIP-AND-FALL FORM

Patient Name: _____ Date: _____
Address: _____ City _____ Zip _____
Home Telephone: _____ Work Telephone: _____
Date of Birth: _____ Social Security No: _____

IF YOU FELL, HOW DID IT HAPPEN

(Include details such as: Why it happened, how did you respond (i.e., hands reached forward), if your body twisted, if you hit the floor/ground, and what parts of your body that hit)

_____
_____
_____
_____
_____

IF SOMETHING HIT YOUR HEAD, DESCRIBE HOW IT HAPPENED

(Include details such as: Why it happened, how did you respond (i.e., hands reached forward), if your body twisted, if you hit the floor/ground, and what parts of your body that hit)

_____
_____
_____
_____
_____

☐ Yes, ☐ No Did you have any bruises or lumps on your head or face? If yes, please describe where: _____
_____

WHERE DID THE INJURY OCCUR?

(Check area(s) where you have had pain or had injury)

☐	Top of your head	☐	Eye area
☐	Back of your head	☐	Upper jaw area
☐	Side of your head	☐	Lower jaw area
☐	Forehead above eyes	☐	Ear region
☐	Neck region	☐	Other:

(Doctor's Name, Address, Telephone)

Form 4130

Name and address of Chiropractor with whom Patient & Attorney are authorizing lien.

LIEN AUTHORIZATION
TO PAY CHIROPRACTIC FEES
-and Constructive Trust for the Chiropractor-

ATTORNEY NAME/ADDRESS:
Date of Injury:

PATIENT NAME/ADDRESS:
Social Security No:

PATIENT AGREEMENT

I hereby authorize the above Chiropractor to communicate with, and furnish, my attorney, a full report of his/her examination, diagnosis, treatment, and prognosis of my injuries, arising from the accident in which I was involved, if requested, and copies of my medical records.

I further authorize and irrevocably direct you, my attorney, **to pay directly to above Chiropractor** such billings and fees as may be due and owing to him for these chiropractic services/treatment, X-rays, reports, all deposition time, all arbitration or mediation time, court appearances, transcription time, and costs rendered to me by reason of this accident. You, my attorney, are further irrevocably directed to pay such billings and fees from funds held for me in your client trust account, or to withhold such sums from any settlements, judgments, dispositions, proceeds, payments or verdicts received by you on my behalf as may be necessary to adequately protect above Chiropractor. I hereby further, irrevocably, give a lien on my case to above Chiropractor against any and all proceeds of any settlements, judgments, dispositions, proceeds, payments or verdicts which may be paid to you, my attorney, or myself, as a result of the injuries which necessitated diagnostic testing, examination, and treatment.

I fully realize and understand that I am directly and fully, personally responsible to the above Chiropractor for all chiropractic billing and that ***this obligation is not contingent upon my receiving any settlement for my claim***. With this in mind, I agree to give the above Chiropractor all information concerning any and all insurance policies which may cover my chiropractic treatment and diagnosis. I further agree to notify the said Chiropractor's office and to pay his/her billings at such time as I may personally receive payments made directly to myself from any of the involved insurance carriers.

Should I receive payment for the above Chiropractic fees and have not turned said monies over to the above Chiropractor within thirty (30) days, or should I fail to perform my obligation to pay these fees, then the entire amount of the Chiropractor's billing shall bear interest at the highest rate permitted by law from the date chiropractic services were rendered.

In the event I discharge my present attorney, or change or substitute another attorney, at any time, prior to payment in full for all chiropractic billing and other charges, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I agree to notify said Chiropractor of any change in attorney status and will provide a signed lien to the Chiropractor within five working days. If my new attorney does not honor this lien for any reason, or if I have no legal representation for any reason, then I will pay all of said Chiropractor bills in full within thirty (30) days.

(Continued on Other Side-Page 2)

Lien Authorization-(Continued from Side One)

Chiropractor's Name:

PATIENT AGREEMENT CONTINUED (PAGE TWO OF LIEN)

I agree to be responsible for any legal fees, court, or collection agency costs incurred, which may be necessary to enforce this agreement. Those additional expenses for legal or collection agency fees or court costs, will be added on top of the billings and/or fees of said Chiropractor along with the highest interest rate permitted by law, calculated from the date chiropractic services were first rendered. I understand that, in view of the protracted time for cases to be tried, I waive any right to statute of limitations for collections.

I hereby appoint the said Chiropractor at the address on this lien as my Attorney-in-Fact, to act in my name and place, and on my behalf with authority to endorse any checks issued to me in payment for Chiropractic fees. This contract is binding upon me, whether or not signed by my attorney.

A photocopy reproduction of this authorization and signature may be used in place of the original.

PHYSICIAN (CHIROPRACTOR) AGREEMENT

The physician shall provide Attorney, at intervals upon Attorney's request, with complete reports of patient-client's medical condition and care and cost of treatment. The physician agrees to furnish these reports within a reasonable time after each request at a reasonable cost.

ATTORNEY AGREEMENT

The undersigned, being the attorney of record for the above-mentioned patient, does hereby agree to observe all the terms of the above **Chiropractic Lien and agrees to withhold such sums In Trust** from any payments, proceeds, dispositions, settlements, judgments, or verdicts as may be necessary to adequately protect said Chiropractor. This lien is given with the understanding that it applies only to the net proceeds received, after deduction of attorney's fees and costs of suit. Furthermore, this lien is to be treated on a pro rata basis, with all other liens of equal stature. Counsel further agrees to notify said Chiropractor in writing, at such time as this patient's case is surrendered to the patient/client or is transferred to a new attorney. The undersigned also represents and warrants to said Chiropractor that he/she has explained fully to his/her client, all of the legal ramifications of the foregoing chiropractic lien for services rendered including, but not limited to, its irrevocability, its waiver of the defense of the statute of limitations and its provision for direct payments of chiropractic billings. Furthermore, counsel agrees, that after receiving monies, to send payment to said Chiropractor within thirty (30) days or be charged an additional finance charge at the highest interest rate permitted by the law for every month that the suit has been settled and/or chiropractic payments have been received and said Chiropractor remains unpaid. Counsel agrees to pay all legal fees and court costs should this lien necessitate enforcement through the legal process.

EFFECTIVE DATE OF THIS AGREEMENT. The effective date of this agreement will be the date of its execution by the last of the parties to do so. The foregoing is agreed to by:

Dated:_____ Physician's Signature:_____

Dated:_____ Patient's Signature:_____

Dated:_____ Attorney's Signature:_____

☺ Attorney, please date, sign your name on this agreement, and then promptly return this form to said Chiropractor's office after making a copy for your own records.

LIEN REDUCTION POLICY LETTER TO ATTORNEY

Date:

Attorney Name/Address:

RE: Patient Name:

Dear

You have contacted my office requesting that I reduce my billing amount. This letter is being sent to you to clarify my office policy regarding reducing my office charges for this patient. As you know, I am under no obligation to reduce my fees. However, in this case because of my desire to help this patient financially I am willing to reduce my total billing charges by _____ percent as long as three requirements stated below (A-C) have been fully completed by your office first.

A. I will reduce my total office fees by _____ percent as long as every provider (MD, DC, PT, Emergency Room, and hospital) and you (plaintiff's attorney) reduce their fees by the same percentage amount.

B. I must have this percentage fee reduction financial arrangement in writing from your office with the patient receiving a letter to this effect. I must have copies of every other provider acknowledging his/her agreement to reduce fees by same percentage.

C. as you are in charge of the client trust account, you are legally required to give a final accounting statement to your client. I must receive a copy of this statement which must reflect the discount amount for all providers and yourself.

My office policy is firm on these three requirements.

Sincerely,

Name

(Doctor's Name, License Number, Address, and Telephone)

NOTICE OF PI CASE CLOSURE TO INSURANCE COMPANY

Date:

Name of Injured Patient:
Date of Injury:
Claim Number:
Employer:
Insurance Company/Address:

This letter is to inform you that the above mentioned injured patient, who has been treated in my office, has had his/her case closed on the following date:_____.

THIS PATIENT HAS:

☐	Reached Maximum Medical Improvement status with no ratable factors of disability. He/She has reached pre-injury status and requires no future Chiropractic treatment.
☐	Reached Maximum Medical Improvement status. He/She currently has persistent pain and/or other symptoms (non-ratable factors of disability/impairment) and has not reached pre-injury status.
☐	Reached Maximum Medical Improvement status. He/She has pain levels that interfere with activities of daily living (ratable factors of disability/impairment) and has not reached pre-injury status.
☐	Has reached point in treatment where he/she is not expected to improve further (Maximum Medical Improvement). Future supportive treatment (is/is not) needed for this patient.

At your request, a further narrative report may be obtained. Our office expects prepayment for any reports. Call my office if you have any questions.

Physician's Signature: _____

(Doctor's Name, Address, & Telephone)

NOTICE OF PERSONAL INJURY CASE CLOSURE TO ATTORNEY

Date:

Attorney Name:
Address:
City/State/Zip:

Name of Injured Patient:
Date of Injury:

This letter is to inform you that the above mentioned injured patient, who has been treated in my office, has had his/her case closed on the following date:	Date:

You need to contact this office/clinic and request a closing narrative report. Please be specific in your request as to the detail and length of the requested report. Unless an arrangement has been made with the treating doctor/office, the attorney is expected to include payment for the report at the time of request. This means that when the Doctor receives payment, the report process starts. All reports include data about the injury and any factors relating to disability and prognosis.

THIS PATIENT HAS:

☐	Reached Maximum Medical Improvement status with no ratable factors of disability. He/She has reached pre-injury status and requires no future Chiropractic treatment.
☐	Reached Maximum Medical Improvement status. He/She currently has persistent pain and/or other symptoms (non-ratable factors of disability/impairment) and has not reached pre-injury status.
☐	Reached Maximum Medical Improvement status. He/She has pain levels that interfere with activities of daily living (ratable factors of disability/impairment) and has not reached pre-injury status. You are advised to request a report to outline all factors of disability/impairment.
☐	Has reached point in treatment where he/she is not expected to improve further (Maximum Medical Improvement). Future supportive treatment (is/is not) needed for this patient.

Short reports (1-2 pages): Cost is: $
Long reports (3-4 pages): Cost is: $

Doctor's Signature: _____

(Doctor's Name, Address, & Telephone)

PHYSICIAN'S PROGRESS REPORT-PERSONAL INJURY

PATIENT NAME: _____ Report Date: _____
Claims Adjuster: _____ Claim Number: _____
Employer: _____ Date of Injury: _____

I. REASON FOR SUPPLEMENTAL REPORT

☐	Periodic patient status report
☐	Change in employees work status
☐	There is a measurable change in this patient's condition, requiring significant change in treatment plan.
☐	Physician referral indicated/performed
☐	Diagnostic testing indicated/performed
☐	Need for surgical consultation
☐	

II. PATIENT STATUS-RESPONSE TO TREATMENT

A. Patient status since the last report/exam or current response to treatment indicates the following:

☐	Treatment continues to lessen this patient's pain intensity level and/or symptom frequency
☐	Treatment continues to improve this patient's functional capacity levels
☐	Since the last report, this patient's condition has improved (Normally/Slower than expected)
☐	Since the last report, this patient's condition has (Not improved/Worsened) overall
☐	Worsened slightly due to (normal activities at home-work/flare-up/new injury)
☐	Worsened significantly due to (normal activities at home-work/flare-up/new injury)

B. Discussion: _____
_____
_____

C. Current Diagnosis: ICD _____ | _____ Describe_____
_____

III. CURRENT PAIN LOCATIONS AND DESCRIPTIVES

	LOCATION	INTENSITY	FREQUENCY	RESOLVED
☐	Headache/Migraine	None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	
☐	Neck pain/Stiffness	None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	
☐	Mid back/Rib cage pain	None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	
☐	Low back/SI//Hip pain	None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	
☐	Upper extremity symptoms	None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	
☐	Lower extremity symptoms	None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	
☐		None/Min/Slight/Moderate/Severe	None/Occasional/Frequent/Constant	

IV. OBJECTIVE FINDINGS

1.
2.

Page Two-Personal Injury Progress Report

V. TREATMENT PLAN & OBJECTIVES (PRESENT AND FUTURE):

☐ Spinal adjustments (areas of fixation)	☐ Flexion distraction	☐ Improve joint ROM
☐ Myotherapy/Trigger point therapy	☐ Electrical modalities	☐ Reduce pain
☐ Posture/Ergonomic modification	☐ Ice/Heat packs	☐ Stabilize condition
☐ Cervical/Lumbar Traction (home/office)	☐ Bracing/Orthotics	☐ Improve Functional Capacity
☐ Exercises/Stretching (home/office)	☐	☐ Enhance repair

VI. PLANNED COURSE OF TREATMENT (Estimate)

OVERALL TIME FRAME ESTIMATE FOR FUTURE TREATMENT	☐ 4-6 weeks ☐ 8-10 weeks ☐ 12-14 weeks ☐
TREATMENT WILL CONTINUE AT THE INDICATED FREQUENCY AND WILL LESSEN AS THIS PATIENT'S CONDITION IMPROVES ☐ Yes ☐ No Patient complying with treatment regimen	☐ Daily for 1-2 weeks, ☐ 3x week for _____ weeks ☐ 2x week for _____ weeks ☐ 1x week for _____ weeks ☐ ___x every ___ wks/mo for _____ months ☐ Seen on an as needed basis only.

VII. PRESENT WORK STATUS

☐	Full time work status with no limitations and/or modifications
☐	Full time work status with limitations/modifications (Temporary/Permanent)
☐	Total (temporary/permanent) disability. Expected date to return to work is:
☐	☐ Light duty, ☐ Part time work, ☐ Currently unemployed

VIII. OUTCOME ESTIMATE/PROJECTIONS OVERALL

☐	I do not anticipate residual symptoms and/or permanent disability/impairment at this time
☐	I am unable to anticipate residual symptoms or permanent disability/impairment at this time
☐	I anticipate residual nondisabling symptoms from this injury at the conclusion of treatment
☐	I anticipate residual permanent disabling symptoms and/or impairment at the conclusion of treatment
☐	Patient (has/has not) reached pre-injury status
☐	Patient has now reached maximum medical improvement (MMI)
☐	Patient has not yet reached maximum medical improvement. (Unable to predict when/Will be able) to better predict on the following date:
☐	Patient's condition is stabilizing and should reach MMI by the following date:

_____

(Treating Physician's Signature)

(Doctor's Name, License Number, Address, and Telephone)

MOTOR VEHICLE COLLISION INJURY REPORT

Patient Name:	Address:		Home Telephone:
Claim No:	Date of Injury:		Date of First Treatment:
Patient Date of Birth:	Name of Employer:		Job Title:
Patient's Description of Motor Vehicle Collision:			
Prior Injuries or Illness: List Complicating Factors:			
Prior Treatment for Injury:	☐ No, ☐ Yes If yes, indicate where:		
Present Symptoms: (Severity and Frequency)			
Physical Exam Findings:			
Diagnosis:			
Diagnosis:			
X-Ray: (Indicate date/findings)	☐ No X-rays Taken Date Findings ☐ Yes X-rays Taken		
Other Testing: (MRI, EMG, CT, etc)	☐ None Name of Test Date Findings ☐ Yes		
Types of Treatment Given: (List Modalities, etc)			
Current Treatment Status: (If Discharged give Date)	☐ Discharged From Care Date of Discharge: ☐ Currently Under Care		
Response to Therapy:			
Disability Dates:	☐ None, ☐ Yes Indicate Dates:		
Prognosis: (If unknown, indicate why)	☐ Good, ☐ Unknown, ☐ Guarded If guarded, Describe:		
Permanent Impairment or Disability:	☐ None, ☐ Unknown, ☐ Yes If yes, Describe:		
Present Work Restrictions:	☐ None, ☐ Yes If yes, Describe:		
Misc Notes:			
Date of Report:	Physician's License Number:	Physician's Tax ID No:	Physician's Telephone:
Physician's Address (Street, Suite, City, State, Zip):			
Physician's Name:	Signature of Physician:		

Form 4450

NOTICE OF NEW INJURY TO INSURANCE CARRIER

Date of Notice:

Patient Name:
Claim Number:

Carrier
Name/Address:

Dear Sir/Madam,

This notice is to inform you that the above patient has been involved in a second injury. All billing for the first injury is now temporarily suspended. The insurance carrier responsible for the second injury will be billed for any future office visits until the patient's injuries and injury related symptoms have reached pre-injury status.

FIRST INJURY	SECOND INJURY
Date of Injury:	Date of Injury:
Insurance carrier:	Insurance Carrier:
Claim Number:	Claim Number:
Claim Adjuster:	Claim Adjuster:
Nature of Injury:	Nature of Injury:

This patient has been comparatively evaluated in history, interview, and examination as to his/her status; prior to and after the second injury. Any changes in pain intensity and frequency, objective and subjective factors of disability, and overall physical changes have been noted in the patient's medical records.

Our office wants you to know that treatment and billing to your office will resume once this patient has achieved his/her pre-injury status. At that time you will be notified. At your request, with a signed release from the patient, a report will be furnished to you in regards to apportionment issues. If you have any questions, please feel free to contact my office.

Doctor's Signature: _____

(Doctor's Name, Address, & Telephone)

FEE STRUCTURE FOR DEPOSITION AND TRIAL TESTIMONY

Attorney Name: _____ Date: _____

The doctor (indicated below) has the following fee schedule (see below) for giving deposition and trial testimony. All deposition and trial testimony time is billed in 15-minute increments.

Payment for the pre-agreed upon deposition time is to be fully paid before the deposition begins. Billing starts on time even if the parties are late. The doctor (below) does not do billing for deposition time. This means that the attorney requesting the deposition needs to have already sent payment to the doctor or to bring a completed check for the time allotted. If the deposition goes beyond the pre-arranged time paid for, the attorney must have some method of payment at the conclusion of the deposition.

Payment for trial testimony is also billed in 15-minute increments. This billing includes any waiting time or lunch time breaks during testimony. Prior to any trial testimony the doctor must be paid in full for all preparation/research time and any reports generated. After the trial has concluded, the attorney will be billed, and full payment is expected within 30 days. No discounts are given regardless of verdict or settlement amount.

	FEES CHARGED PER HOUR
• Driving time	$
• Deposition testimony time	$
• Trial testimony time	$
• Preparation time	$
• Record review time	$
•	$

Please make checks payable to the doctor indicated at the bottom of this form. The doctor's tax ID number is indicated below.

(Doctor's Name/Address/Telephone/Tax ID)

CASE WORKSHEET FOR DEPOSITION OR TRIAL

Patient:_____ Date attorney first contacted doctor about case going to trial: _____

Attorney Name: _____
Address: _____
Office Telephone: _____ Fax: _____

Deposition Date/Time/Location: _____
Trial Date/Time/Location: _____

Doctor Retained as **(Treating Physician Only/Expert Witness)** and will testify in the areas of:

❑ Treatment	❑ Injury biomechanics	❑ Malpractice issues
❑ Diagnosis	❑ Prognosis	❑

Date	CV and Record Status
	CV and Fee Schedule Mailed/Faxed to Attorney
	Records Received

Date	Phone Contact	Personal Meeting	Time Spent	Discussion

Date	Record Review Time	Research Time

Notes about case: _____
_____
_____
_____

(Doctor's Name/Address/Telephone)

CHIROPRACTOR-ATTORNEY DEPOSITION AGREEMENT

Date of Agreement: _____
Case Name: _____

AGREEMENT WITH THE FOLLOWING PARTIES

Chiropractor's Name and Address	Attorney's Name and Address

This agreement will confirm arrangements for professional services made between the Chiropractor listed above and the attorney requesting his/her deposition listed above. The objective of this agreement is to avoid any later misunderstanding regarding agreed services and agreed charges. The chiropractor requires 24 hours advance notice of cancellation of a deposition. This notice must include both a) a telephone call and b) a fax or written notice. The attorney listed in this agreement will be charged for the anticipated length of deposition if cancelled in less than 24 hours.

DEPOSITION ARRANGEMENTS

Date and Time of Deposition:	Date: Time:
Location of Deposition (Address and Suite Number):	
Hourly Fee (Billed in 15-minute increments):	$ Per Hour
Anticipated Length of Deposition:	Hours

The attorney listed above agrees to fully pay the fee for the anticipated length of the deposition before the commencement of the deposition. Any deposition time that goes beyond the anticipated length is to be fully paid at the conclusion of the deposition. The attorney agrees to bring a check or make other financial arrangements to pay for any outstanding balance at the conclusion of the deposition.

I (_____) attorney, do hereby agree to abide by the conditions outlined in this agreement.

Signature of Attorney: _____ Date: _____

(Doctor's Name and Address)
