



Automobile Accident Paperwork

It is important that each section of our Auto Accident forms are fully completed. All the information provided here is used to generate an insurance report that is required to be sent to your Insurance company. Any questions that are not answered will result in a delay of your information and invoices being sent to your insurance company for reimbursement.

Personal Information:

First name: _____ Last name: _____

Address: _____

City: _____ State: _____ Zip: _____

e-mail: _____

Home phone: _____ Cell phone: _____

Date of Birth: _____ Dominant hand: Right Left

Date of Injury: _____

Please describe accident in detail:

Accident Details: Please answer the questions below. This section pertains to you and the accident. If a question is not applicable, please write NA.

Your Vehicle Type: <input type="radio"/> Car <input type="radio"/> S.U.V. <input type="radio"/> Van <input type="radio"/> Bus <input type="radio"/> Large Truck <input type="radio"/> Pickup Truck	Your Position in Vehicle <input type="radio"/> Driver <input type="radio"/> Front Passenger <input type="radio"/> L.Rear Passenger <input type="radio"/> R.Rear Passenger Other Position: _____
Year, make and model of vehicle: _____	
Time/Speed/Damage Time of Accident: _____ Your Speed _____ Their Speed _____	Damage to your vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled
What was your vehicle doing at time of accident? <input type="radio"/> Stopped at intersection <input type="radio"/> Stopped in traffic <input type="radio"/> Stopped at a light <input type="radio"/> Making a right turn <input type="radio"/> Making a left turn <input type="radio"/> Parking <input type="radio"/> Proceeding along <input type="radio"/> Slowing down <input type="radio"/> Accelerating Other: _____	
Details of Accident:	
Visibility at the time: <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	Road Conditions at Time of Accident: <input type="radio"/> Icy <input type="radio"/> Wet <input type="radio"/> Sandy <input type="radio"/> Dark <input type="radio"/> Clean & Dry
Point of Impact: <input type="radio"/> Head-On <input type="radio"/> Rear-End <input type="radio"/> Left front <input type="radio"/> Right front <input type="radio"/> Left rear <input type="radio"/> Right rear Other: _____	Who hit who/what: <input type="radio"/> You hit other vehicle <input type="radio"/> Other vehicle hit you <input type="radio"/> You hit ... (Type in object below) Other: _____
Additional Accident Information: _____	
During the Accident:	
Body Position, etc. Did you see the accident coming?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the driver's front air bag deploy?.. Yes <input type="checkbox"/> No <input type="checkbox"/> Did passenger front air bags deploy? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the side air bags deploy?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Does your vehicle have headrests? ... Yes <input type="checkbox"/> No <input type="checkbox"/>	Headrest Position? <input type="radio"/> Even with top of head <input type="radio"/> Even with bottom of head <input type="radio"/> Even with middle of the neck
What was the direction of the head at the time of impact? <input type="radio"/> Facing straight forward <input type="radio"/> Turned to the right <input type="radio"/> Turned to the left	

Did your body strike the inside of your vehicle?..... Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, describe: _____	
Did you lose consciousness during the injury?..... Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, for how long? _____	
Your vehicle's Estimated Damage: _____	Damage to their vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled
Did police show up at the scene? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was an accident report filled out? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, name of Police department: _____	
Emergency Room?	
Where did you go after the accident? <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Hospital ER <input type="radio"/> Private doctor	How did you get there? <input type="radio"/> Drove Self <input type="radio"/> Ambulance <input type="radio"/> Somebody Else <input type="radio"/> Police
Name of Hospital / Urgent care / Private doctor: _____	
X-rays done? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was lab work done? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Body parts X-rayed? _____	What lab work? _____
The x-rays revealed: _____	
Treatments: <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Ice Other: _____	
Medications: _____	
Follow-up instructions: _____	
After the Accident: Check off the symptoms right after and a few days following the accident.	
<input type="checkbox"/> Headache <input type="checkbox"/> Loss of smell <input type="checkbox"/> Tension <input type="checkbox"/> Loss of taste <input type="checkbox"/> Diarrhea <input type="checkbox"/> Neck pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Irritability <input type="checkbox"/> Toe numbness <input type="checkbox"/> Depression <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Nausea <input type="checkbox"/> Mid back pain <input type="checkbox"/> Constipation <input type="checkbox"/> Anxious <input type="checkbox"/> Fainting <input type="checkbox"/> Confusion <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Chest pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Cold Feet <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping problems	
Others: _____	

Description of Symptoms: Please indicate each area of your body that was injured in your accident. Each body part (Location of Pain) is to be described individually. Ex: if you injured your neck, shoulder, and hips you will choose Neck as your 1st area of concern, and under Location of pain, check Neck and describe the pain associated with your neck. ie: pain type, frequency, radiating pain etc. Under 2nd area of concern, choose shoulder and describe the pain associated with that body part. Continue with 3rd area and 4th area if needed.

Please choose which side of the body was affected.

- L = Left
- R = Right
- B = Both sides

1st area of concern

Choose FIRST body part injured, and describe pain associated with it.

<p>Location of Pain:</p> <input type="checkbox"/> Headaches LO RO BO <input type="radio"/> Front of Head <input type="radio"/> Top and/or Sides <input type="radio"/> Back of Head <input type="checkbox"/> Jaw..... LO RO BO <input type="checkbox"/> Eye..... LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Uppr. Back.. LO RO BO <input type="checkbox"/> Mid Back.... LO RO BO <input type="checkbox"/> Low Back.... LO RO BO <input type="checkbox"/> Chest..... LO RO BO <input type="checkbox"/> Abdomen.... LO RO BO <input type="checkbox"/> Ribs..... LO RO BO <input type="checkbox"/> Buttocks.... LO RO BO <input type="checkbox"/> Shoulder.... LO RO BO <input type="checkbox"/> Uppr. Arm... LO RO BO <input type="checkbox"/> Foreman.... LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO <p>Other Locations: <input type="text"/></p> <p>Types of Pain:</p> <input type="checkbox"/> Dull <input type="checkbox"/> Numbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Spasm <input type="checkbox"/> Cutting <input type="checkbox"/> Sharp <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Pounding <input type="checkbox"/> Stinging <input type="checkbox"/> Cramping <input type="checkbox"/> Aching <input type="checkbox"/> Constricting <p>Other Types of Pain: <input type="text"/></p> <p>Pain Frequency:</p> <input type="radio"/> Up to 1/4 of awake time <input type="radio"/> 1/4 to 1/2 of awake time <input type="radio"/> 1/2 to 3/4 of awake time <input type="radio"/> Most all the time	<p>Does this Pain Radiate?</p> <input type="checkbox"/> Head.....LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Shoulder...LO RO BO <input type="checkbox"/> Arm.....LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO <p>Other Locations: <input type="text"/></p> <p>Actions Affecting Pain B=Brings on A=Aggravates R=Relieves B A R</p> <input type="checkbox"/> In the A.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In the P.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Fwd <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coughing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Straining <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lifting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <p>Other Actions: <input type="text"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pain Intensity:</p> <input type="radio"/> Doesn't affect daily activities <input type="radio"/> Somewhat affects activities <input type="radio"/> Seriously affects activities <input type="radio"/> Prevents activities
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2nd area of concern

Choose SECOND body part injured, And describe pain associated with it.

<p>Location of Pain:</p> <input type="checkbox"/> Headaches LO RO BO <input type="radio"/> Front of Head <input type="radio"/> Top and/or Sides <input type="radio"/> Back of Head <input type="checkbox"/> Jaw..... LO RO BO <input type="checkbox"/> Eye..... LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Uppr. Back.. LO RO BO <input type="checkbox"/> Mid Back.... LO RO BO <input type="checkbox"/> Low Back.... LO RO BO <input type="checkbox"/> Chest..... LO RO BO <input type="checkbox"/> Abdomen.... LO RO BO <input type="checkbox"/> Ribs..... LO RO BO <input type="checkbox"/> Buttocks.... LO RO BO <input type="checkbox"/> Shoulder.... LO RO BO <input type="checkbox"/> Uppr. Arm... LO RO BO <input type="checkbox"/> Foreman.... LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO <p>Other Locations: <input type="text"/></p> <p>Types of Pain:</p> <input type="checkbox"/> Dull <input type="checkbox"/> Numbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Spasm <input type="checkbox"/> Cutting <input type="checkbox"/> Sharp <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Pounding <input type="checkbox"/> Stinging <input type="checkbox"/> Cramping <input type="checkbox"/> Aching <input type="checkbox"/> Constricting <p>Other Types of Pain: <input type="text"/></p> <p>Pain Frequency:</p> <input type="radio"/> Up to 1/4 of awake time <input type="radio"/> 1/4 to 1/2 of awake time <input type="radio"/> 1/2 to 3/4 of awake time <input type="radio"/> Most all the time	<p>Does this Pain Radiate?</p> <input type="checkbox"/> Head.....LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Shoulder...LO RO BO <input type="checkbox"/> Arm.....LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO <p>Other Locations: <input type="text"/></p> <p>Actions Affecting Pain B=Brings on A=Aggravates R=Relieves B A R</p> <input type="checkbox"/> In the A.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In the P.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Fwd <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coughing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Straining <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lifting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <p>Other Actions: <input type="text"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="text"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pain Intensity:</p> <input type="radio"/> Doesn't affect daily activities <input type="radio"/> Somewhat affects activities <input type="radio"/> Seriously affects activities <input type="radio"/> Prevents activities
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Description of Symptoms: Please indicate each area of your body that was injured in your accident. Each body part (Location of Pain) is to be described individually. Ex: if you injured your neck, shoulder, and hips you will choose Neck as your 1st area of concern, and under Location of pain, check Neck and describe the pain associated with your neck. ie: pain type, frequency, radiating pain etc. Under 2nd area of concern, choose shoulder and describe the pain associated with that body part. Continue with 3rd area and 4th area if needed.

Please choose which side of the body was affected.

- L = Left
- R = Right
- B = Both sides

3rd area of concern

Choose THIRD body part injured, and describe pain associated with it.

- Location of Pain:**
- Headaches LO RO BO
 - Front of Head
 - Top and/or Sides
 - Back of Head
 - Jaw..... LO RO BO
 - Eye..... LO RO BO
 - Neck..... LO RO BO
 - Uppr. Back.. LO RO BO
 - Mid Back.... LO RO BO
 - Low Back.... LO RO BO
 - Chest..... LO RO BO
 - Abdomen.... LO RO BO
 - Ribs..... LO RO BO
 - Buttocks.... LO RO BO
 - Shoulder.... LO RO BO
 - Uppr. Arm... LO RO BO
 - Foreman.... LO RO BO
 - Hand..... LO RO BO
 - Hip..... LO RO BO
 - Leg..... LO RO BO
 - Foot..... LO RO BO

- Other Locations:**
- _____

- Types of Pain:**
- Dull Numbing
 - Throbbing Shooting
 - Spasm Cutting
 - Sharp Tingling
 - Burning Pounding
 - Stinging Cramping
 - Aching Constricting
- Other Types of Pain:**
- _____

- Pain Frequency:**
- Up to 1/4 of awake time
 - 1/4 to 1/2 of awake time
 - 1/2 to 3/4 of awake time
 - Most all the time

- Does this Pain Radiate?**
- Head..... LO RO BO
 - Neck..... LO RO BO
 - Shoulder... LO RO BO
 - Arm..... LO RO BO
 - Hand..... LO RO BO
 - Hip..... LO RO BO
 - Leg..... LO RO BO
 - Foot..... LO RO BO

Other Locations:

- Actions Affecting Pain**
B=Brings on A=Aggravates
- | R=Relieves | B | A | R |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Fwd | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Rt. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting Left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting Rt. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Other Actions:**
- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Pain Intensity:**
- Doesn't affect daily activities
 - Somewhat affects activities
 - Seriously affects activities
 - Prevents activities

4th area of concern

Choose FOURTH body part injured, and describe pain associated with it.

- Location of Pain:**
- Headaches LO RO BO
 - Front of Head
 - Top and/or Sides
 - Back of Head
 - Jaw..... LO RO BO
 - Eye..... LO RO BO
 - Neck..... LO RO BO
 - Uppr. Back.. LO RO BO
 - Mid Back.... LO RO BO
 - Low Back.... LO RO BO
 - Chest..... LO RO BO
 - Abdomen.... LO RO BO
 - Ribs..... LO RO BO
 - Buttocks.... LO RO BO
 - Shoulder.... LO RO BO
 - Uppr. Arm... LO RO BO
 - Foreman.... LO RO BO
 - Hand..... LO RO BO
 - Hip..... LO RO BO
 - Leg..... LO RO BO
 - Foot..... LO RO BO

- Other Locations:**
- _____

- Types of Pain:**
- Dull Numbing
 - Throbbing Shooting
 - Spasm Cutting
 - Sharp Tingling
 - Burning Pounding
 - Stinging Cramping
 - Aching Constricting
- Other Types of Pain:**
- _____

- Pain Frequency:**
- Up to 1/4 of awake time
 - 1/4 to 1/2 of awake time
 - 1/2 to 3/4 of awake time
 - Most all the time

- Does this Pain Radiate?**
- Head..... LO RO BO
 - Neck..... LO RO BO
 - Shoulder... LO RO BO
 - Arm..... LO RO BO
 - Hand..... LO RO BO
 - Hip..... LO RO BO
 - Leg..... LO RO BO
 - Foot..... LO RO BO

Other Locations:

- Actions Affecting Pain**
B=Brings on A=Aggravates
- | R=Relieves | B | A | R |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Fwd | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending Rt. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting Left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting Rt. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Other Actions:**
- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Pain Intensity:**
- Doesn't affect daily activities
 - Somewhat affects activities
 - Seriously affects activities
 - Prevents activities

Activities of Daily Living: Using the following 1-5 scale, choose the number that describes the difficulties listed below.

- 1 = I can do it without any difficulty
- 2 = I can do it without much difficulty, despite SOME pain
- 3 = I manage to do it by myself, despite MARKED pain
- 4 = I manage to do it despite the pain, but only if I have help
- 5 = I cannot do it at all, because of the pain

Self care					
Personal Hygiene	1	2	3	4	5
Bathing					
Drying hair					
Brushing teeth					
Putting on shoes					
Preparing meals					
Taking out the trash					
Showering					
Combing hair					
Making the bed					
Tying shoes					
Eating					
Doing laundry					
Washing hair					
Washing face					
Putting on a shirt					
Putting on pants					
Cleaning dishes					
Going to the toilet					

Physical Activities	1	2	3	4	5
Standing					
Walking					
Kneeling					
Bending back					
Twisting left					
Leaning back					
Sitting					
Stooping					
Reaching					
Bending left					
Twisting right					
Leaning left					
Reclining					
Squatting					
Bending forward					
Bending right					
Leaning forward					
Leaning right					
Standing for long periods					
Sitting for long periods					
Walking for long periods					
Kneeling for long periods					

Functional Activities	1	2	3	4	5
Carrying small objects					
Lifting weights off the floor					
Pushing things while seated					
Exercising upper body					
Carrying large objects					
Lifting weights off table					
Pushing things while standing					
Exercising lower body					
Carrying brief case					
Climbing stairs					
Pulling things while seated					
Exercising arms					
Carrying large purse					
Climbing inclines					
Pulling things while standing					
Exercising legs					

Social and Recreational	1	2	3	4	5
Bowling					
Jogging					
Swimming					
Ice skating					
Competitive sports					
Dating					
Golfing					
Dancing					
Skiing					
Roller skating					
Hobbies					
Dining out					

Activities of Daily Living: Using the following 1-5 scale, choose the number that describes the difficulties listed below.

- 1 = I can do it without any difficulty
- 2 = I can do it without much difficulty, despite SOME pain
- 3 = I manage to do it by myself, despite MARKED pain
- 4 = I manage to do it despite the pain, but only if I have help
- 5 = I cannot do it at all, because of the pain

Difficulties with Traveling	1	2	3	4	5
Driving a motor vehicle					
As a passenger in a motor vehicle					
As a passenger on a train					
Driving for long periods of time					
As passenger in an airplane					

For the 4 sections below, please use the following scale to that best represents your difficulties with Communication, senses, hand functions and sleep.

- 1 = This area is NOT affected by my condition
- 2 = This area is SLIGHTLY affected by my condition
- 3 = My condition MODERATELY restricts my ability in this area
- 4 = My condition SERIOUSLY limits my ability in this area
- 5 = My condition PREVENTS me from using this ability

Difficulties with Communication	1	2	3	4	5
Concentrating					
Hearing					
Listening					
Speaking					
Reading					
Writing					
Using a keyboard					

Difficulties with Senses	1	2	3	4	5
Seeing					
Hearing					
Touch					
Taste					
Sense of smell					

Difficulties with Hand Functions	1	2	3	4	5
Grasping					
Holding					
Pinching					
Percussive movements					
Sensory discrimination					

Difficulties with Sleep	1	2	3	4	5
Being able to have a normal, restful nights sleep					



184 Mammoth Rd Unit 6
Londonderry, NH 03053
phone 603-434-8300 fax 603-965-1057

Auto Accident Billing Policy

All billing from our office, pertaining to your auto accident will be sent to your Insurance Company that you have listed below, for processing. Per New Hampshire State law (RSA 264:16), checks are mailed directly to you, the policyholder and **not** sent to our office.

Due to the NH state law, our office policy requires patients to pay for the services rendered at the time of your visit. This ensures that your account is paid and up to date.

In NH, when you are involved in an auto accident, you must open a Med-pay Claim with your own insurance company. The state of NH requires your insurance company to collect funds from the at-fault insurance company. We must bill to your insurance company for services rendered.

Claim number: _____

Insurance company: _____

Date of Accident: _____

Parent Chiropractic Center
J. Daniel Parent, D.C.
Tax ID # 02-0478056

Patient Signature

Date

Parent/Guardian signature
(if patient under 18 years of age)

Date



Auto Accident Information sheet

Patient Name: _____

Date of Accident: _____

Insurance Company Information:

Patient Auto Insurance Company Name: _____
(NOT the at fault insurance co.)

Auto Insurance **Billing** Address: _____

City / state / zip _____

Telephone # of Auto Insurance Company: _____

Auto Insurance Claim Number: _____ (not your policy number)

Auto Insurance Adjuster Name: _____

Adjuster Telephone Number (ext.): _____

Adjuster Fax Number: _____

Med Pay Amount: \$ _____

Any additional info: _____

Important to note: In the state of NH, you **MUST** open a claim with **YOUR** insurance company, we must bill to your insurance company. If you are not at fault, the insurance company will seek funds from the at-fault party's insurance company.



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Signature: _____ Date of last menstrual period: _____

I authorize **Parent Chiropractic Center** to speak to _____,
(Relationship) _____ regarding any treatments/concerns related to my healthcare.

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

I have read and fully understand the above statements and accept chiropractic care on this basis.

Signature: _____ date: _____



Consent for Purpose of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by J. Daniel Parent for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of J. Daniel Parent.

I understand that diagnosis or treatment of me by Parent Chiropractic Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Parent Chiropractic Center is not required to agree to the restrictions that I may request. However, if J. Daniel Parent agrees to a restriction that I may request, the restriction is binding on J. Daniel Parent and Parent Chiropractic Center.

I have the right to revoke this consent in writing, at any time, except to the extent that Parent Chiropractic Center or J. Daniel Parent has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review J. Daniel Parent's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Parent Chiropractic Center.

The Notice of Privacy Practices also describes my rights and the duties of Parent Chiropractic Center with respect to my protected health information.

The Notice of Privacy Practices for Parent Chiropractic Center is also provided at 184 Mammoth Road, Unit 6, Londonderry, NH 03053 and on the Parent Chiropractic Center web-site.

J. Daniel Parent reserves the right to change the privacy practices that are described in the Notices of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Parent Chiropractic Center web-site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name or Personal Representative

Signature of Patient or Personal Representative

Date

Relationship to Patient