**RAINIER VALLEY CHIROPRACTIC P.S.**
*David A. Butters D.C.* – Natasha Butters D.C. –Mitchell Gottschalk D.C.
4236 36th Avenue S. Seattle, WA 98118
Phone 206-723-2820 Fax 206-722-3664

## Auto Collision Patient History

Date _____ cell# _____ Home# _____ E-mail _____

First Name _____ Middle _____ Last _____

Street Address _____ City _____ Zip Code _____

❑Male ❑Female Date of Birth ___/___/_____ Age _____ ❑Married ❑Single

Number of children ____ Are you currently pregnant? ❑No ❑Yes ____ months Are you nursing? ❑No ❑Yes

## Collision Information

Date of Collision ___/___/_____ Time _____AM/PM City _____ State _____

Which were you? ❑The Driver

The Passenger: ❑Front seat Back seat: ❑Behind driver ❑Middle seat ❑Behind front passenger

Or were you a ❑Pedestrian?

Were you: ❑Aware or ❑Unaware of the collision prior to impact?

What direction was your head facing at impact? ❑Straight Ahead ❑Turned to the Left ❑Turned to the Right

Other, Please Explain: _____

_____

Were you wearing a ❑Seatbelt with a shoulder harness or ❑Lap belt only? ❑No Seatbelt?

Describe where the headrest was in relation to the top of your head: ❑Above ❑Below ❑Don't know

Did the airbag deploy? ❑No ❑Yes Road conditions were: ❑Dry ❑Wet ❑Icy ❑Snowy ❑Unsure

Did the police come to the collision scene? ❑No ❑Yes

Where was the impact on your car? Front of car: ❑Center ❑Left Front ❑Right Front

Rear end of car: ❑Center ❑Left Rear ❑Right Rear

Side of car: ❑T-boned ❑Side-swipe ❑Front half of car ❑Back half of car

Describe how the accident occurred: _____

_____

_____

_____

Did you hit any body parts on the inside of the vehicle? ❑No ❑Yes, Where? _____

Did you have any visible cuts or bruises? ❑No ❑Yes, Where? _____

Did you lose consciousness? ❑No ❑Yes, How long? _____

How soon after the accident did your pain begin? _____

**Is this accident job related? ❑No ❑Yes, Have you reported it, and when?** _____

**Has an on-the-job injury claim been filed? ❑No ❑Yes, Claim #** _____

**Employer at time of injury:** _____ **Phone Number:** _____

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Name_____ Date: ____/____/_____

## Information about the Vehicle You Were In

Year _____ Make _____ Model _____
Approximate property damage to your vehicle, if known $_____

## Information about the Other Vehicle

Year _____ Make _____ Model _____

If more than one other vehicle was involved please explain _____

## Treatment Information

Did you go to the emergency room/ hospital? ❑No ❑Yes, When? _____
How did you get there?_____ Name of Hospital_____
Were X-rays/ MRIs/ CT scans taken? ❑No ❑Yes, Of what body parts? _____

Treatment: ❑Admitted ❑Exam and Discharge ❑Neck collar ❑Ice/Heat ❑Medical Aids (crutches, etc.)
❑ Medications (Please list) _____
Follow up instructions/ referrals: _____

Please list **other health care providers** you have seen for the condition(s), and **treatment** received.

Name & Location of Primary Care Physician (your family doctor): _____

## Since the collision have you been experiencing:

❑Dizziness ❑Balance problems ❑Nausea ❑Vomiting ❑Confusion/ Disorientation ❑Seizures
❑Headache ❑Memory problems ❑Loss of consciousness, # of episodes # of minutes_____

## Today's Major Complaints

***Please check*** ✓ ***Please*** (Circle) ***Your Level of Pain.***

| ***Area of Pain and Type of Pain*** | | | | | | | ***0= No Pain through 10=Extreme Pain*** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑Headache | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Neck Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Shoulder Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Arm Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Mid Back Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Low Back Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Hip Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Leg Pain | ❑Lt ❑Rt | ❑Ache | ❑Dull | ❑Sharp | ❑Stabbing | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Other _____ | | | | | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ❑Other _____ | | | | | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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Name_____ Date: ____/____/_____

# Health History

## Cardiovascular/ Pulmonary/Respiratory:

| | | | | |
|---|---|---|---|---|
| ❑Heart/vascular conditions | ❑ History of stroke | ❑Low blood pressure | ❑High blood pressure | ❑Difficulty breathing |
| ❑Lingering cough | ❑Asthma | ❑Chest congestion | ❑Chest pain | ❑Bronchitis |
| ❑Pneumonia | ❑Allergies | ❑Swollen ankles | ❑Frequent colds | ❑Sinus problems |

## Gastrointestinal:

| | | | | |
|---|---|---|---|---|
| ❑Heartburn | ❑Diarrhea | ❑Ulcers | ❑Stomach problems | ❑Liver problems |
| ❑Vomiting of blood | ❑Irritated colon/bowel | ❑Gallbladder problems | ❑Constipation | ❑Hemorrhoids |

## Urinary/Reproductive:

❑Bladder problems ❑Kidney problems ❑Prostate trouble ❑ Menstrual problems

## General/Other:

❑Fatigue ❑Poor Sleep ❑Difficulty swallowing ❑Diabetes ❑Thyroid problems ❑History of cancer

Any other problems not listed:_____

_____

**Current Height**_____ **Current Weight**_____

What have you been doing at home to make your symptoms feel better? _____

**Please indicate any medications or drugs you are taking:**

❑Anti-depressive medication ❑Stimulants ❑Insulin ❑Tranquilizers ❑Cholesterol medicine
❑Pain killers (prescribed/OTC) ❑Muscle relaxers ❑Blood pressure medication ❑Blood Thinners
Others: _____ _____ _____

**Please list any prior falls, accidents, or other traumatic injuries:**

| Month/ Year | Type of Accident | Please describe accident/injury |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please list any prior fractures, surgeries or serious illnesses:**

| Month/ Year | Type of Illness | Please describe |
|---|---|---|
| | | |
| | | |
| | | |

**Please list any serious diseases suffered by members of your immediate family (ex: cancer, heart disease, diabetes)**

_____

_____

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Name_____ Date: ____/____/_____

## Work/ Social History

What is your occupation?_____
Employer _____ Work Phone _____
Employer's Address _____
Have you lost time from work as a result of this injury? ❑No ❑Yes, Dates _____
Are you being compensated for time lost? ❑No ❑Yes Return to work date _____
Are you working: ❑Full time ❑Part time ❑Regular duty ❑Restricted duty
Explain any restrictions:_____

**I feel more pain when doing the following activities:**

**Check ✓ the activities that cause pain and then (Circle) minimal, mild, moderate or severe.**

| | | | | |
|---|---|---|---|---|
| ❑Sleeping | Minimal | Mild | Moderate | Severe |
| ❑Sitting | Minimal | Mild | Moderate | Severe |
| ❑Walking | Minimal | Mild | Moderate | Severe |
| ❑Standing | Minimal | Mild | Moderate | Severe |
| ❑Lifting | Minimal | Mild | Moderate | Severe |
| ❑Household Chores | Minimal | Mild | Moderate | Severe |
| ❑Routine Personal Care | Minimal | Mild | Moderate | Severe |
| ❑Child Care | Minimal | Mild | Moderate | Severe |
| ❑Sports/ Exercise | Minimal | Mild | Moderate | Severe |
| ❑Yard Work | Minimal | Mild | Moderate | Severe |
| ❑Other | Minimal | Mild | Moderate | Severe |

| | | | | | | |
|---|---|---|---|---|---|---|
| Do you drink alcohol? | ❑No | ❑Yes, | ____ Drinks | ❑Daily | ❑Weekly | ❑Monthly |
| Do you smoke? | ❑No | ❑Yes, | ____ Packs | ❑Daily | ❑Weekly | ❑Monthly |
| Do you exercise? | ❑No | ❑Yes, | If yes, then how often? | ❑Daily | ❑2-3 times a Week | ❑Monthly |

## 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-ray can be hazardous to an unborn child.

**Date of Last Menstrual Period:** ____/____/_____

_____ ____/____/_____
*(Signature)* *(Date)*

_____ _____
***(Patient Signature. If minor, parent or guardian signature)*** ***(Date)***

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

## Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

## Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Neck Index Score* _____

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

## Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

## Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

## Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

## Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

## Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

## Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

## Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

## Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score*

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Name_____ Date: ____/____/_____

## Office Billing Policy Regarding Treatment of Patients Involved in Automobile Collisions

At your initial appointment we require that you provide us your Auto Insurance information and the Insurance information of any at fault party. This includes: names of Auto Insurance Companies, claim numbers, claim managers names, phone numbers, etc.

## Personal Injury Protection (PIP)

If you have Personal Injury Protection (PIP) on your auto insurance policy it is Primary and must be billed 1st. PIP is an optional benefit on most if not all auto insurance policies. You pay a specific additional monthly premium to have PIP on your auto policy. Washington State requires auto insurers to include the PIP protection option on your policy unless you specifically sign a waiver refusing it. Many if not most people in Washington State have PIP on their policy. Your general health insurance will not pay for your auto injury related treatment if or while you have unused PIP benefits.

## General Health Insurance

If you do not have Personal Injury Protection (PIP) on your Auto Policy your General Health Insurance Plan may pay for some of your care. However, before they will pay you must inform them that you were in an Auto Collision and provide them proof that you do not have Personal Injury Protection (PIP) on your Auto Policy. In most cases they will require you to sign a document indicating that you do not have (PIP) and allowing them to subrogate (get paid back) when there is a settlement with the insurance company of the individual that caused your accident. Your General Health Insurance coverage is limited by your health plan benefits, deductibles, co-pays, co-insurance, etc.

## Third Party Claim

The Third Party is the party at fault when someone else caused your accident. If you do not have Personal Injury Protection (PIP) and you do not have General Health Insurance what you're left with is possibly a Third Party Claim against the party that caused the collision and/or possibly a Uninsured Motorist Claim against your own Auto Insurance Policy. **Third Party and/or Uninsured Motorist Policy's do not pay for treatment until all of your treatment is concluded and there is a settlement of the claim. In some cases this can be 1-2 years or longer after the collision.**

Under the following conditions and on an individual basis we sometimes accept Third Party and/or Uninsured Motorist claims and we wait for payment until treatment is concluded and your claim is settled:

1) **There are no other payment sources 2) The patient has legal representation 3) We file a Medical Lien against settlement proceeds from the at fault insurance company.**

I _____ have read and accept the above Billing Policy's.

Sign _____ Date_____

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Name_____ Date: ____/____/_____

## Insurance Information

Who was at fault for the accident? _____

**Do you have Auto Insurance (Personal Injury Protection)? If so, please fill in the following:**

**Name of your insurance:** _____
Claims office address: _____
_____
Claim #: _____ Phone number of your insurance: _____
Name of your adjustor: _____

**Name of insurance for the other involved party/3rd Party:** _____
Claims office address: _____
_____
Claim #: _____ Phone number of insurance company: _____
Name of the adjustor: _____

**If you have an attorney, please fill out the following:**
Name of Attorney: _____
Address: _____
Phone Number: _____

## Assignment of Insurance Benefits

I hereby authorize payment directly to Rainier Valley Chiropractic P.S. for the treatment of _____
*(Patient Name)*

I understand that I am financially responsible to the doctor for charges not covered by this assignment.

_____ ____/____/_____
*(Signature of Policy Holder or Patient)* *(Date)*

## Authorization to Release Records to PIP

I hereby authorize Rainier Valley Chiropractic P.S. to send treatment records relating to the injury of ____/____/_____ to my Personal Injury Protection carrier.
*(Injury Date)*

_____ ____/____/_____
*(Signature of Policy Holder or Patient)* *(Date)*

## Personal Injury Protection and Third Party Settlements/ Auto

I hereby authorize payment directly to Rainier Valley Chiropractic P.S. for Chiropractic care relating to the injury of ____/____/_____ to my Personal Injury Protection carrier. I understand that Rainier Valley Chiropractic P.S. (RVC) will file a medical lien if I have a 3rd party only claim and/or if my Personal Injury Protection (PIP) benefits have been exhausted. Liens are released after the claim settles and proceeds due RVC are received.
*(Injury Date)*

_____ ____/____/_____
*(Signature of Policy Holder or Patient)* *(Date)*

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Name_____ Date: ____/____/_____

## Authorization To Release Medical Records:

### PATIENT INFORMATION:

Name (print) _____ DOB _____ SSN _____

### INFORMATION TO BE RELEASED FROM:

1) Name of facility or provider
_____ Ph#_____ Pt. Initials _____
Address
_____ Fax#_____ Date Sent ___/___/___

2) Name of facility or provider
_____ Ph#_____ Pt. Initials _____
Address
_____ Fax#_____ Date Sent ___/___/___

3) Name of facility or provider
_____ Ph#_____ Pt. Initials_____
Address
_____ Fax#_____ Date Sent ___/___/___

### INFORMATION TO BE SENT TO:

**Rainier Valley Chiropractic, P.S.**
**4236 36th Avenue S., Seattle, WA 98118**
**206-723-2820 (fax # 206-722-3664)**

### INFORMATION TO BE RELEASED: (check one)

__X__ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify):

### PURPOSE FOR WHICH THE DISCOSURE IS BEING MADE: (please check one)

_____ Attorney _____Insurance __X__Doctor _____Personal

### PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ Drug/Alcohol abuse/treatment & diagnosis
_____ HIV/AIDS diagnosis/treatment testing
_____ Sexually transmitted disease
_____ Mental illness or psychiatric diagnosis/treatment

### MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization ma re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

**This authorization will expire 90 days from the date signed**