PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Last Name:	**MI:** **First Name:**	
Home Address:		
City:	State:	Zip:
E-Mail:	Cell Phone:	Text: Yes No
Date Birth: Age: Gender M F	Social Security No:	
Employer:	Work Phone:	
Emergency Contact:Name:	Relationship:	
Address:	Phone:	

AUTOMOBILE INSURANCE INFORMATION

Is there insurance coverage for the vehicle you were in? ☐Yes ☐No	☐ I have, ☐ Someone else has coverage. Name of person policy is under:
How is this person related to you? ☐ Self, ☐ Parent ☐ Friend ☐ Other	
Name of your Auto Insurance Carrier:	
Have you reported this injury to your insurance carrier? ☐ Yes, ☐ No	
Claim Adjusters Name:	Claim Adjuster's phone #:
Claim #:	
Were the police called to the scene? ☐yes ☐no	Was Either Driver Cited by Police?
Driver of Other Vehicle:	
Their Insurance Company:	Their Insurance Phone #:

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

<u>Our office will provide insurance billing services for you if you so desire as a courtesy</u>.

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

Your signature on this document indicates that you:

1) *Agree to pay for any outstanding bills incurred in this office.*
2) *Authorize the release of information necessary to secure the payment of benefits.*
3) *Authorize insurance payments to be made directly to Summit Chiropractic & Massage.*
4) *Authorize the use of this signature on all insurance submissions.*
5) *Authorize us to communicate through text/email. (Treatment related only and will NOT be shared)*

Do you have an attorney representing you? ☐ No ☐ Yes provide information:	Attorney Name: _____ Address_____ Telephone:

Signature of responsible party (Patient or Parent)_____ Date _____

Patient Information
Summit Chiropractic & Massage
7302 NE 18th Street, suite #102, Vancouver WA 98661 * 360-750-7220

Name: _____ **Date:** _____

Welcome to Summit Chiropractic & Massage. We want you to enjoy life to the fullest of your potential.

Reason for your visit today (check all that apply):

❑ stay healthy ❑ peak performance ❑ wellness evaluation ❑ fix the problem ❑ pain relief only

Complete this section only if you have symptoms
(this will be necessary for most insurances)

Date problem began? _____

Describe how this problem began (fall, lift, etc.)?

_____

_____

_____

Circle your current pain level: **0 1 2 3 4 5 6 7 8 9 10**

Check how often do you experience your symptoms:

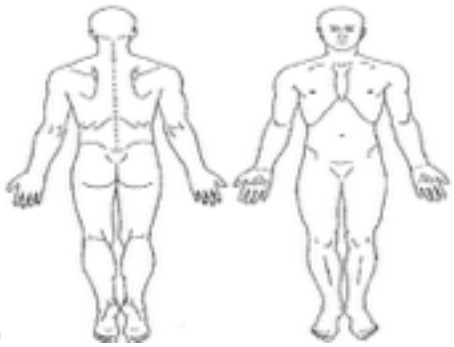
❑ Constantly (90-100%) ❑ Frequently (70-80%)
❑ Intermittently (40-60%) ❑ Occasionally (10-30%)
❑ 1x/month ❑ 2-3x/month ❑ 1x/week ❑ 2-4x/week ❑ Daily

Since it began is your complaint (circle): better worse same?

Does the complaint radiate anywhere? No Yes

If yes, Where? Leg Arm Other _____

Circle your current complaint area?



What best describes your complaint? (circle all that apply)

tension	stiffness	tightness
achy	sharp	burning
shooting	throbbing	stabbing
numbness	tingling	weakness
other:		

What makes your symptoms better _____

What makes your symptoms worse? _____

What daily activities are being affected? _____

Prior care/treatments? _____

Office/Doctor use

Summit Chiropractic & Massage Patient Information

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HAS YOUR COMPLAINT BEEN ASSOCIATED WITH OR HAVE YOU RECENTLY HAD:?

☐ **None of the following** Check all that apply.

☐ Recent excessive fatigue	☐ fever	☐ night pain / night sweats
☐ Unintentional weight loss/gain	☐ Change in bowel or bladder habits	☐ difficulty with talking/balance/confusion/dizziness
☐ Abdominal pain / pulsations	☐ Kidney pain / change in urination	☐ changes in vision (double/blurred)
☐ Chest pain / shortness of breath	☐ Weakness / numbness in a limb	☐ vomiting/diarrhea/constipation
☐ skin rash	☐ pain worse with rest	☐ other symptoms not mentioned:

SURGERY?

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

Surgery	Year	Surgery	Year
☐ Spine surgery (neck or back)		☐ Cancer / chest / head / pelvis	
☐ shoulder / arm / hip / leg / hand / foot		☐ Other	

MEDICAL CONDITIONS / ILLNESS ?

☐ **I have no prior/current other conditions /illnesses.** Check all that you currently have or have ever had.

☐ Diabetes / Pre-Diabetes	☐ cancer (any type)	☐ heart attack / stroke	☐ heart disease
☐ scoliosis	☐ arthritis (anywhere)	☐ seizures / neurological	☐ osteoporosis / osteopenia (weak bones)
☐ herniated / degenerated discs	☐ high blood pressure	☐ abdominal aneurysm	☐ arm / leg numbness tingling weakness
☐ high cholesterol	☐ anxiety / depression	☐ asthma / allergies	☐ Crohn's / psoriasis / ulcerative colitis
☐ other conditions not mentioned:			

PRIOR INJURY HISTORY?

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

☐ low back injury ☐ neck/mid-back injury ☐leg/arm injury ☐ sports injury ☐vehicle/motorcycle injury ☐ Other:
Details:

FRACTURES/BROKEN BONES?

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

Region	Year	Region	Year
☐ Spinal (neck/back)		☐ Skull / Pelvis	
☐ Arm / leg / foot / hand		☐ other:	

MEDICATIONS?

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

☐ Muscle relaxants/anti-inflammatory/steroids Details:	☐ Blood pressure/stroke /heart/cholesterol Detail:	☐ Diabetic Detail:
☐ Pain: prescription or over the counter Detail:	☐ Osteoporosis medications. Details:	☐ Other: Details:

LIFESTYLE

Rate the following:

Exercise/week: 1 2 3 4 5 6 7	**Diet:** poor / good / excellent
Stress level: Low Moderate High	**Tobacco:** yes / never / past

ILLNESSES / CONDITIONS IN YOUR FAMILY: _____

OCCUPATION _____ Physical demands _____

SIGNATURE _____ DATE _____

To the best of my ability, the information I have supplied is complete and truthful.

MOTOR VEHICLE CRASH FORM (Details)

Patient Name:_____ Date: _____

Date of injury:_____ Time of injury _____ ☐ AM ☐ PM

City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry

Street (location) where crash occurred: _____

What is the estimated damage to your vehicle? $_____ who made estimate?_____

Your vehicle? (model/make) Other vehicle? (model/make)

Impact Details ☐single car ☐2 vehicle ☐rear end ☐side ☐head-on ☐other

Your vehicle was: ☐slowing down ☐gaining speed ☐stopped ☐steady speed

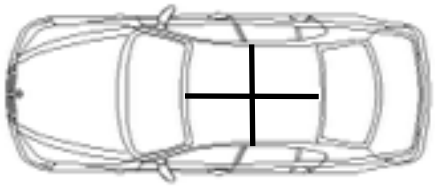
Other vehicle was: ☐slowing down ☐gaining speed ☐stopped ☐steady speed

During/after impact: ☐stayed straight ☐spun L / R ☐hit another object:

Describe crash: _____

_____

Mark area of damage to vehicle and X your sitting position



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	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other

YES	NO	INDICATE THOSE RELEVANT TO YOUR CASE
☐	☐	Were you wearing a seatbelt? ☐Lap/shoulder ☐Lap only ☐no seatbelt in vehicle
☐	☐	Driver: Was your foot on the brake at impact?
☐	☐	Driver: Were you holding onto the steering wheel?
☐	☐	Was the door(s)/trunk/hood of your vehicle damaged to point where you could not open them?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes ☐side air bag ☐front air bag
☐	☐	Did you have any bruising after the crash? Where?

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all that apply.

☐	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 braced yourself before the collision.
☐	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 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 seat back If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso and body was positioned normally against the seat back with no gaps due to leaning/twisting

Functional Rating Index

Name: _____ For use with **Neck and/or Back Problems** Date: _____

(Print)

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0----------1----------2----------3----------4

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0----------1----------2----------3----------4

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0----------1----------2----------3----------4

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0----------1----------2----------3----------4

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0----------1----------2----------3----------4

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0----------1----------2----------3----------4

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0----------1----------2----------3----------4

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0----------1----------2----------3----------4

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0----------1----------2----------3----------4

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0----------1----------2----------3----------4

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Signature: _____ Total Score: _____/40 _____%

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