BELFAIR CHIROPRACTIC CENTER

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

We need this information because your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name: _____ Sex: _____ Birthday_____

Address: _____ City: _____State: _____ Zip: _____

Home phone# _____ Mobile Phone #_____

Soc. Sec# _____ Work Phone # _____Employer _____

Please explain in detail how your accident happened: _____

_____

_____

Your Insurance: _____**Policy#:** _____**Claim#** _____

Your Ins. Adjuster: _____**Adjuster Phone#:** _____**Fax#:** _____

Is there another driver involved? ☐*Yes* ☐*No* ***Is this driver at Fault?*** *Yes or No* ***(If yes please complete the following):***

Name of Driver at fault: _____***Insurance Company:*** _____***Policy#:***_____

Ins. Adjuster: _____***Claim #*** _____***Phone#:*** _____

Have you retained an attorney? ☐*Yes* ☐*No* Attorney Name:_____Phone#:_____

Were the Police Notified? ☐*Yes* ☐*No* Was a report filed? ☐*Yes* ☐*No* What County? _____

Place accident occurred?_____What was the date of collision?_____
Was the vehicle moving at the time of impact? ☐Yes ☐No Estimated speed _____mph

Where were you seated in the car? _____

Were you aware of the approaching collision? ☐Yes ☐No What position was the headrest? ☐High ☐Middle ☐Low

Was your foot on the brake or clutch? ☐Yes ☐No _____Were your hands on the steering wheel? ☐Yes ☐No

Were you wearing your seatbelt? ☐Yes ☐No Did your airbags deploy? ☐Yes ☐No Did you strike the airbag? ☐Yes ☐No

Did you strike the interior of the vehicle with any part of your body? ☐Yes ☐No Please explain _____
Did you feel pain immediately? ☐*Yes* ☐*No* Please explain _____

_____

Did you receive visible cuts and bruises? ☐*Yes* ☐*No* Please explain _____
Were you knocked unconscious? ☐Yes ☐No For how long?_____
Were you taken anywhere immediately after the accident ☐Yes ☐No Where?_____

Did you consult any doctor after this collision ☐Yes ☐No Who? _____ __☐DC ☐MD ☐DO ☐DDS
Did you receive treatment? ☐Yes ☐No What treatment did you receive? _____

_____

What was your diagnosis? _____
Have you ever had the same complaints as your current injuries? ☐Yes ☐No Are your current symptoms worse or the same as your previous complaints and to what degree?_____
Before this injury were you capable of working on an equal basis with others your age? ☐Yes ☐No
Are your work activities restricted as a result of this accident? ☐Yes ☐No? To what degree? _____
Since this injury have your symptoms ☐ Improved ☐Worsened ☐ Same?
Have you noticed limitations in normal, daily activities that you didn't experience prior to this collision, please explain:_____

Signature:_____***Date***_____

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.
Balances still owed after 90 days will be charged a 1% finance fee. Returned check fee is $55.

Personal Injury Protection (PIP) can be billed. For those with no PIP coverage or with a 3rd Party case a PI attorney must be consulted.

Massage no-show or late cancellation fee is $50.00 _____(initial) This cannot be billed to Insurace or PI Claim
I understand I must give notice of 24 hour of cancellation _____(initial)
I am responsible for remembering my own appointments, this office offers text reminders but they are a courtesy, not a reliable way to remember appointments_____(initial)

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Belfair Chiropractic Center.

I understand that the Notice describes the uses and disclosures of my protected health information by Belfair Chiropractic Center and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

Informed Consent for Chiropractic Care

Every type of health care is associated with some risk of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement of Washington State.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine (drop Table). Frequently adjustments create a "pop" or "click" sound or sensation in the area of treatment.
In this office we may use trained staff personnel to assist the doctor with portions of your consultation, physical therapy application, traction, Cold Laser therapy, massage therapy, exercise instruction, etc. Occasionally when you doctor is unavailable; staff may treat you on that day.
This office uses cold low-level laser therapy which produces no heat and cannot result in a burn.

Neck Artery Dissection and Stroke: Dissection is when the lining of a neck artery brakes down. This might happen spontaneously or from an injury or from a trivial movement (hair shampooing, checking traffic, looking up, folding laundry, etc.) Dissections tend to cause neck pain and/or headache. Dissections may form from a blood clot that can dislodge and interfere with brain blood flow. If that happens it is called a stroke. Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019) although the same evidence often suggests that a patient may be entering the chiropractic office for neck pain/ headaches or other symptoms that may be in fact a spontaneous dissection of a neck artery. There are NO in-the-office tests to diagnose a spontaneous neck artery dissection (2020) but they may be detectable with advanced imaging (CT/MRI). If we think you may be suffering from a spontaneous neck artery dissection and/or associated stroke we will immediately refer you to the emergency room.

Anecdotal cases suggest that chiropractic adjustments may be associated with dissection and/or stroke that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment". We do not perform this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of complication ranges between
1 per every 400,000-10,000,000 neck adjustments (2004). A large 10-year study estimated an incidence of 1 per 5.85 million neck adjustments, equivalent to 1,430 years of clinical practice (2001). If you experience any of the "5**D**'s **A**nd 3 ***N***'s" (on a page following) before or after an adjustment please tell us immediately. Also please read and fill out and sign the **Stroke Risk Factors**.

Three other potential problems that are NOT quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury, spinal dural leak of cerebral spinal fluid, and bleeding in the coverings around the spinal column (dural hematoma).

Disc Herniation: Both neck and back disc herniation may create pressure n the spinal nerve or on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments,

traction, etc. Occasionally chiropractic treatment (adjustments/traction etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bladder, bowel and sexual function. Representative symptoms include leaky bladder or leaky bowels or loss of sensation around the pelvic sexual organs, or the inability to start/stop urination or to start/stop a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die and these functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours, depending. If you have any of these symptoms please tell us immediately, if we can't be reached please go to the emergency room immediately.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Rarely chiropractic care may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatment for resolution. There are no long term effects for the patient.

Rib and other fractures: Rarely a chiropractic adjustment may crack a rib bone, and this is called a fracture. We adjust all patients very carefully and especially those who have known osteoporosis. Other fracture locations are extremely rare but possible; especially those aged over 65 years and/or are taking steroid drugs.

Soreness: It is common for chiropractic care to result in a temporary increase in soreness/pain in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. This is not dangerous, but please do tell us of any soreness.

Other Problems: There may be other problems or complications that may arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them in advance of treatment.

Chiropractic is a system of health care delivery and therefore as with any health care delivery system we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care and if results are not acceptable we will refer you for additional diagnostics or to another health care provider whom we feel will assist you in your situation. Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage etc. Risks from these procedures should be discussed with that particular provider.

If you have any questions on the above please ask your doctor. When you have a full understanding, please sign and date below.

_____ _____

Patient's Printed Name Patient's Signature

_____ _____

Parent/Guardian Signature if Minor Today's Date

_____ _____

Doctor's Signature Verifying Discussion Date of Discussion

Massage Therapy Client Release Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- During the session hot stones or hot towels may be used.
- During the session Cupping Therapy may be performed. If I should choose to experience this treatment I understand the potential effects and the after-care recommendations. It has been explained to me there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned in my Health History Intake form, to avoid any complications. It has been explained to me that there can be some discolorations that may occur from the release and clearing of stagnation and toxins from the body. I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors, old stagnation and toxins being drawn to the surface to be cleared away by my circulatory system. I further understand that the discolorations will dissipate from a few hours to as long as two weeks in some cases and in relation to my after-care activities. I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn or when I am hungry or thirsty.
- I understand that I should avoid excessive exposure to extreme cold, wet, and/or windy weather conditions, very hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid and or limit such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats. I understand I should drink plenty of clean water.
- The therapeutic session is scheduled for 60 minutes. This may include the following. Consultation and verbal discussion of subjective findings. Undressing and getting comfortable on the massage table. Hands-on time, this will vary between 50-55 minutes. If the Massage Therapist decides to go over into his or her personal time this is up to their discretion.

Our office bills the 60 minute session in increments of 15 minutes. We bill 4 units to equal the 60 minutes of scheduled time that includes the above mentioned items.

I_____ agree to allow the Massage Practitioner to perform Massage Therapy and/or Cupping Therapy. I have read and understand all the information stated above and will not hold the practitioner responsible.

_____ _____

Signature Date

I_____ agree to be on time for my massage appointment. If I am more than 15 minutes late I forfeit my massage and will pay the no-show/late cancellation fee of $50.

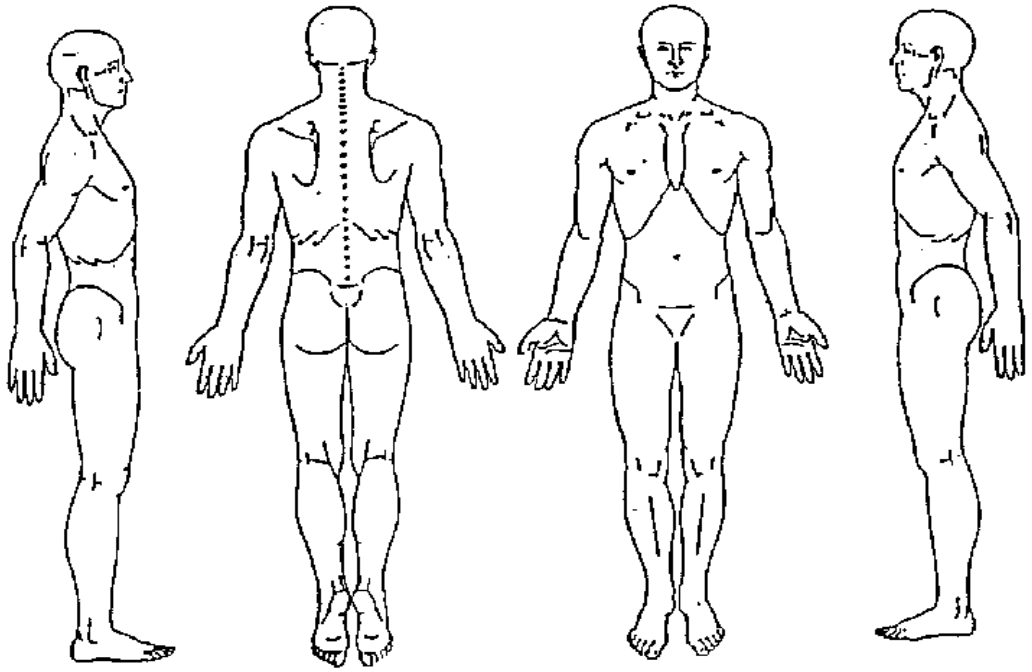
_____ _____

Signature Date

Please mark your symptoms on the diagram:

Mark “P” for pain

Mark “N” and “T” for numbness and tingling



Rate your overall pain today

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild			Moderate		Severe		Worst Possible	

Progression (circle): Improving Not-Improving Worsening

What makes it worse?_____

What makes it better?_____

In general, how would you rate your current overall health?
Excellent Very good Good Fair Poor

List All Medications

_____

_____

_____

Please list all accidents, injuries, surgeries and falls with approx. dates/year

_____

_____

_____

_____

Stroke Risk Factors: The 5D's And 3 N's. Mark "Y" for Yes, "N" for No

Dizziness/vertigo/giddiness/light-headed___ **A**taxia of gait (difficulty walking/coordination___
Drop attacks/loss of consciousness _____ **N**ausea (with or without vomiting)_____
Diplopia (vision problems/loss of vision)____**N**umbness(face or body)_____
Dysarthria (speech difficulty)_____**N**ystagmus (headache/head pain)_____
Dysphagia (difficulty swallowing)_____

Please check all that apply

___ Abdominal Problems	___ Allergies	___Anxiety / irritability	___ Arthritis
___ Asthma	___ Ankle Problems	___ Auto-immune	___ Back Pain
___ Bone Spurs	___ Breast Lumps	___ Breast Pain	___ Breast Implants
___ Bronchitis	___ Bunions	___ Bursitis	___ Buttocks Pain
___ C-Section	___ Cancer	___ Carpal Tunnel	___ Chest Pain
___ Constipation	___ Depression	___ Diabetes	___ Digestion
___ Dizziness	___ Ear Problems	___ Edema (swelling)	___ Fatigue
___ Fibromyalgia	___ Fibroids / cysts	___ Fracture(s)	___ Falls on Tailbone
___ Gallbladder	___GERD	___ Golfers elbow	___ Hamstring(s)
___ Hay Fever	___ Headaches	___ Heart Problem	___ Hemorrhoids
___ Hernia	___ High BP	___ Hip Replacement	___ Infertility
___ Jaw Problems	___ Joint Replacement	___ Liver Problems	___ Lung Problems
___ Migraines	___ Mood swings	___ Knee Problems	___ Neck Pain
___ Numbness/tingling	___ Orthotics	___ Osteoporosis	___ Pain
___ Pelvic Problems	___ Plantar Fasciitis	___ PMS	___ Prostate Problems
___ Rib Problems	___ Sacral Problems	___ Sciatica	___ Scoliosis
___ Shin Splints	___ Shingles / Herpes	___ Shoulder Problems	___ Sinus Problems
___ Sleep Problems	___ Smoker	___ Tennis Elbow	___ Tendonitis

What are your favorite hobbies or activities?_____

_____

Currently Affected? □Yes □No

What activities do are you looking forward to doing long term (even in retirement)?