## AUTO ACCIDENT INSURANCE INFORMATION

Please fill out the questions below to the best of your ability. Thank you.

**PATIENT NAME:** _____

Patient's Date of Birth_____ Social Security # _____

1. **Patient's Auto Insurance Carrier**:
   Company Name _____
   Company Phone _____ Ext. _____
   Claim Number _____
   Adjuster's Name & Number _____

2. **Patient's Private Health Insurance Carrier:**
   Company Name _____
   Company Phone _____
   Policy ID# _____Group #_____
   Subscriber's Name _____ DOB _____

3. **Party At Fault's Auto Insurance Carrier**:
   Company Name _____
   Company Phone _____ Ext. _____
   Claim Number _____
   Adjuster's Name & Number _____

4. **Attorney Information:**
   Attorney Name _____
   Attorney Firm _____
   Attorney Phone _____

5. **Date of Accident:** _____

**Patient's Mailing Address:**

Address _____
City _____ State _____ Zip _____
Phone _____ Work _____ Cell_____

# AUTO INJURY CASE HISTORY

Please fill in this questionnaire **COMPLETELY**. If a section does not apply to you, simply cross it out. This confidential history will be part of your permanent records.

**Please fill out completely & initial the bottom of each page**

**For Office Use Only**

**General Information:**

Date of Injury: _____

Approximate time of Injury: _____

**Accident History Prior to Crash:**

Any previous pain/problems in area injured? (Please answer. If so, explain) _____

_____

Was the accident on the job? □Yes □No

You were: □Driver □Front seat passenger □Rear seat passenger □Other: _____

Vehicle driven by: _____

Your vehicle (year, make, model) _____

Your estimated speed at moment of accident: _____
□Stopped □Slowing □Accelerating

Other vehicle (year, make, model) _____

Other vehicle estimated speed at moment of accident: _____

Road conditions: □Dry □Damp □Wet □Snow □Ice □Other _____

Were you aware of the impending crash? □Yes □No

If so, how much time prior to impact did you know you would be hit?_____

Did your air bag deploy? □Yes □No

If yes, were you struck? □Yes □No

Body position: □Straight □Forward lean Other_____

Head position: Which way were you looking upon impact?

□Straight ahead □Left____º □Right____ºUp____º Down____º

Brakes applied? □Yes □No How soon prior to impact? _____

Brief Accident description:

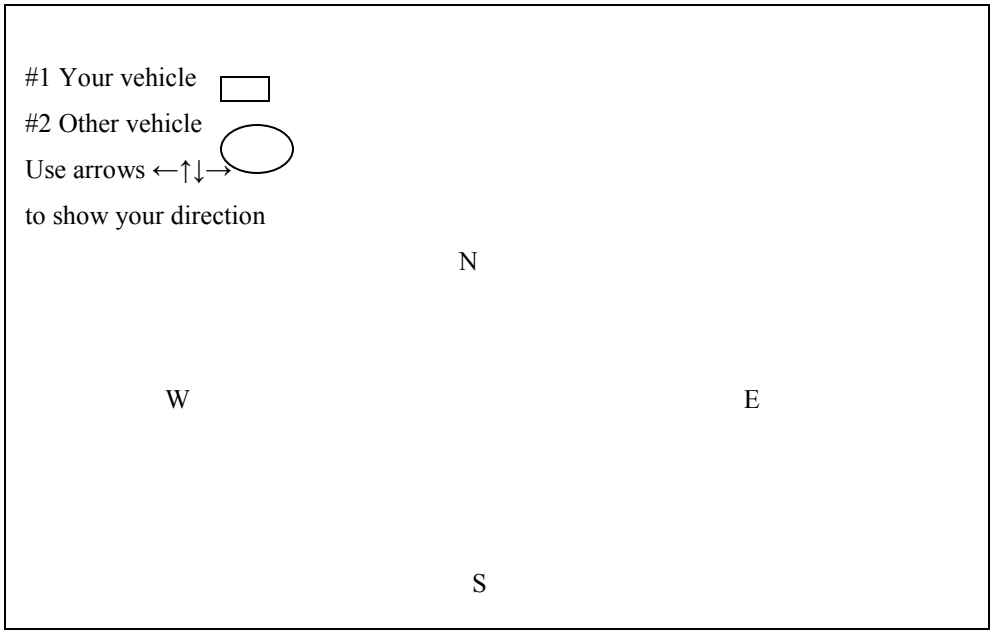
_____

_____

Place Patient Id Sticker Here:

**For Office Use Only**

**Accident Diagram:** Please describe **street names & direction** you were heading. **Draw an "X"** where each vehicle sustained the most damage. A square represents your car (#1) and an oval represents the other car (#2).




## Accident History During the Crash:

Did you strike any parts of the vehicle? □Yes □No

If yes, describe _____

Did you lose consciousness? □Yes □No

If yes, for how long? _____

Please match the body part(s), if any, to the part(s) of the vehicle that were hit during the accident:

| | |
|---|---|
| Head | Windshield |
| Face | Steering Wheel |
| Shoulder | Side Door |
| Neck | Dashboard |
| Chest | Car Frame |
| Hip | Another Occupant |
| Knee | Seat |
| Foot | Seat belt |

## Accident History After the Crash:

Estimated property damage to your vehicle:$_____

Where was your vehicle struck? _____

Estimated damage to other vehicle(s):

□None □Minimal □Moderate □Major

Where was the other vehicle struck? _____

Were the police on-scene? □Yes □No

If yes, was a report made? □Yes □No

Was alcohol involved? □Yes □No

Symptoms:

| | |
|---|---|
| □Headache | □Dizziness |
| □Nausea | □Confusion/Disorientation |
| □Neck Pain | □Back Pain |
| □Arm/ Leg Pain | □Other _____ |

Please describe when you noted each symptom after the crash.

(Eg. Neck pain- immediately, Low back pain- next day)_____

_____

_____

Where did you go after accident? _____

Mode of transportation:_____

**If you have not seen a doctor for this injury within the first month after accident, please indicate reason(s):**

□Did not notice any pain □Time conflict
□Unable to schedule appointment □No transportation
□I thought the pain would disappear □I had no insurance money
□I self treated with over-the-counter drugs □Took hot showers, used
□Other _____ □ Ice/ heat

Have you been unable to work sine the accident? □Yes □No
If yes, were you off work: □partially □Please list dates off work:

_____

## Accident History Emergency Department:

Were you given a neck collar to wear? □Yes □No X-Rays: □Yes □No

Body parts imaged_____

Did the doctor give you a diagnosis? Describe: _____

_____

Lab work □Yes □No

Treatments Performed: _____

_____

Medications:_____

Follow –up instructions: □None □Other: _____

_____

# CHIEF COMPLAINT

**FOR OFFICE USE ONLY**

**Please be sure to fill in each area completely**. Mark the area(s) on your body where you feel the described sensation(s**). Use the appropriate symbol(s).** Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.
Note diagram on the left is front and on right is the back.

Aches ^^^^ Numbness ooooo

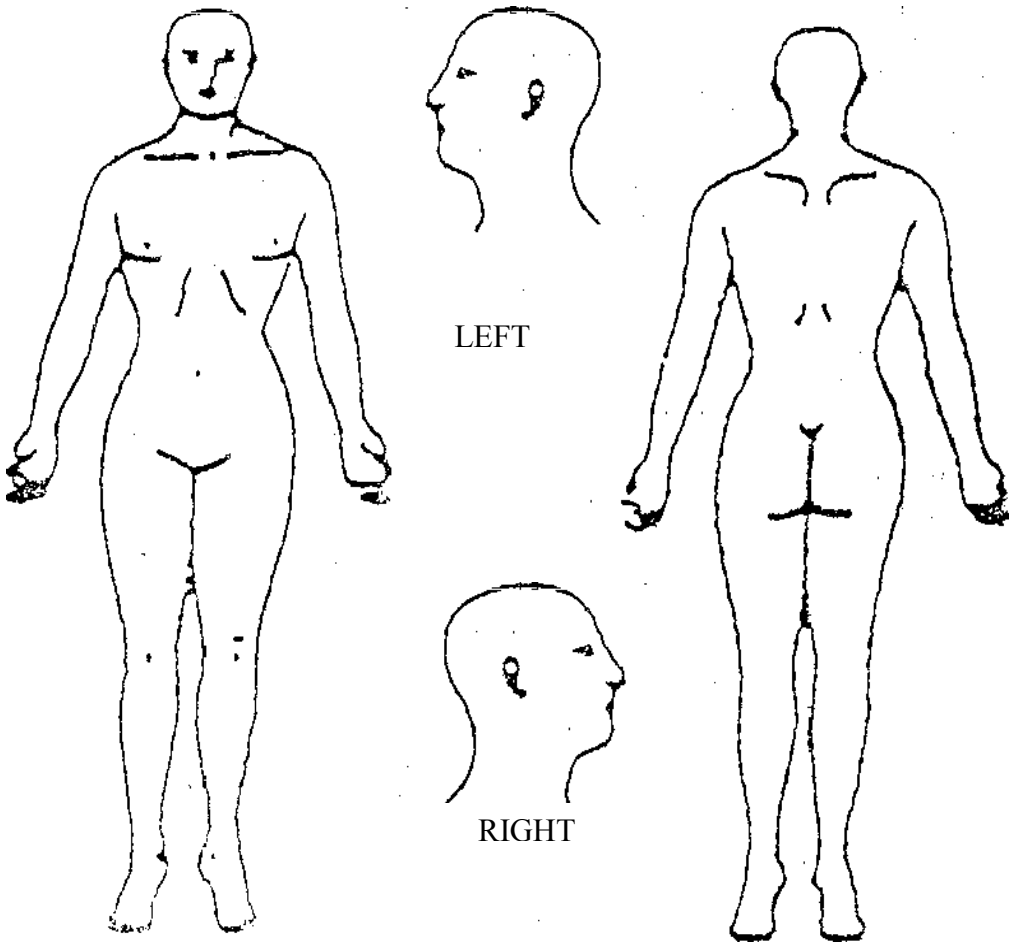
Throbbing TTTTT

Electrical EEEE

Pins/Needles ●●●●

Cramping CCCCC

Burning xxxx Sharp ////




Patient ID Sticker

**What are your major complaints in order of intensity?**

| What are your major complaints in order of intensity? (#1 most bothersome) | Complaint #1 | Complaint #2 | Complaint #3 |
|---|---|---|---|
| | _____ | _____ | _____ |
| Circle How often is your pain | No pain<br>Occasional<br>Intermittent<br>Constant | No pain<br>Occasional<br>Intermittent<br>Constant | No pain<br>Occasional<br>Intermittent<br>Constant |
| List for your complaint which movement makes each area worse | | | |
| List for your complaint which movement makes each area better | | | |
| When during your day are your symptoms worse? | | | |
| When during your day are your symptoms better? | | | |
| Is this condition _____ (please circle) | Improved<br>Mildly improved<br>Unchanged<br>Mildly Worse<br>Getting Worse | Improved<br>Mildly improved<br>Unchanged<br>Mildly Worse<br>Getting Worse | Improved<br>Mildly improved<br>Unchanged<br>Mildly Worse<br>Getting Worse |

On a scale of one-to-ten, how bad are your symptoms **now**?
(With 1 meaning 'no pain', and 10 meaning 'worst possible pain)
On a scale of one-to-ten, how bad are your symptoms **most of the time**?
(With 1 meaning 'no pain', and 10 meaning 'worst possible pain)
On a scale of one-to-ten, how bad have they been **in the past**?
(With 1 meaning 'no pain', and 10 meaning 'worst possible pain)

## FUNCTIONAL INFORMATION

Has pain interfered with your social life, hobbies or sexual ability? Please draw a line to the match ability level of change.

| | |
|---|---|
| Social Life | No Change |
| Hobbies | Minimal Change |
| Sexual Ability | Considerable Change |

Does pain frequently awaken you? ☐Yes ☐No How many hours do you sleep at night? _____

Sleep position: ☐ Back ☐ Stomach ☐ Right side ☐ Left side

In a typical workday, your job requires that you: (8 hrs total)

Sit ___hrs Walk ___hrs Stand ___hrs Bend ___hrs

Is this condition interfering with: (Please Circle) Work, Sleep or other Daily Routines such as reading, housecleaning, driving, sitting, dressing, etc? Discuss what areas of your body you have more problems with due to each activity.

_____

Are you performing an exercise program? When? How often? _____

## PREVIOUS TREATMENT

If applicable, what have you been told is your diagnosis/ problem and by whom? _____

Who is your primary care provider?

Doctor Clinic Name/Address

Last seen Condition

Would you like us to refer you to a primary care provider or to a specialist for another condition you have? Yes / No

What other doctors have you seen in for problem? Please give address if possible.

Doctor Clinic Name/Address Last seen Condition

| **PREVIOUS TREATMENT & RESULTS** | When ? | Have not had treatment | Significant Benefit | Some Benefit | No Help | Worsened Condition |
|---|---|---|---|---|---|---|
| Physical Therapy | | | | | | |
| Chiropractic Manipulation | | | | | | |
| Heating pads, ultrasound, whirlpool, massage, etc | | | | | | |
| Nerve blocks/ Spinal injections | | | | | | |
| Other: _____ | | | | | | |

## DIAGNOSTIC TESTS

Please tell us what tests have been performed in evaluating your condition.

| **TEST** | Date/ Year | Ordering Physician | Location Performed |
|---|---|---|---|
| X-rays/CT scan/MRI | | | |
| EMG/NCV (Nerve tests) | | | |
| Other: _____ | | | |

## PAST INJURY HISTORY

Is this a work related or auto accident injury? ☐ Auto Accident ☐ Work Accident ☐ Neither

Have you had any prior on-the-job injuries? ☐ Yes ☐ No Explain: _____

_____

Have you had any automobile accident injuries? ☐ Yes ☐ No Explain: _____

_____

## PREVIOUS HOSPITALIZATIONS/ INJURIES/SURGERIES

| **Condition?** | **When?** | **Operation (if any):** |
|---|---|---|
| | | |
| | | |

## MEDICATIONS

Please list all the medication that you have been taking recently.

| **Name of Medication** | **Dosage** | **How often** |
|---|---|---|
| | | |
| | | |

## REVIEW OF SYSTEMS

**Please review the following list of medical problems and mark any that apply to you now or in the past.**

Skin (changes in skin, skin conditions, etc)_____

Blood (anemia, lymph nodes, etc)_____

Neurologic (dizziness, vertigo, paralysis, numbness, etc)_____

Endocrine (thyroid, liver, diabetes, etc)_____

Lungs (bronchitis, emphysema, etc)_____

Heart(heart attack, pacemaker, stroke, high blood pressure, etc)_____

Musculoskeletal (weakness, arthritis, pain & stiffness, etc)_____

Gastrointestinal (stomach, intestines, hemorrhoids, etc)_____

Genitourinary (urinary tract, impotence, kidneys, bladder, etc)_____

Psychiatric (depression, drug addiction, hallucinations, suicidal thoughts, irritability)_____

Other condition/disease not mentioned_____

## SOCIAL HISTORY

Date of Birth:_____Age:_____Social Security Number: _____E-Mail: _____

Occupation: _____Employer: _____

Work status: ☐Full time ☐Part time ☐Student ☐Disabled ☐Unemployed ☐Retired

Physical Work ☐Heavy ☐Moderate ☐Light Hours per day _____

Marital Status (check one or more): ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

How long? _____Spouse Name: _____

Number of children: _____Ages: _____

Circle your highest year of school completed:

High School / Tech School / Associates / Bachelors / Masters / Doctorate

Please list an emergency contact:

Name _____ Address _____

Phone# _____ Phone# _____Relation: _____

Current Weight_____ Height _____Tobacco (type, amount per day/week): _____Previous smoker? ☐Yes☐No

Alcohol (amount per day/week): _____

## FAMILY HISTORY

Please list any medical conditions that run in your family:_____

Do you have a family history of spinal/physical problems? (i.e. neck pain, back pain, herniated disc, degenerated disc, sciatica, etc…)

Relation: _____ Condition: _____

_____ _____

## RESULTS OF TREATMENT

What are the results you hope for: **(Check all that are apply)**

☐Pain reduction ☐Increased recreation ☐Improved emotional well-being

☐Return to work ☐ Elimination of drugs ☐Better daily function

What other activities would you like for us to help you get back to?_____

_____

What do you hope will be the results of this evaluation: **(Check all that apply to you)**

☐Medical diagnosis (discover the cause of the pain) ☐Recommendation for treatment

☐Recommendation for rehabilitation ☐Recommendation for surgery

☐Other, describe _____

If you were treated at another office and were dissatisfied with your care, how can we improve on your experience with us?_____

Is there an attorney handling your injury case?

Name: _____Phone Number: _____

## Address:

_____

## REFERRAL INFORMATION

Who can we thank for referring you?

Patient: _____ Physician:_____

Advertisement: _____ Other: _____

### CURRENT TREATMENT INTERESTS

Are you interested in: **(Check all that apply)**

- ☐ DRS Low Back Treatment
- ☐ Chiropractic with Occupational or Physical Therapy
- ☐ Free Spinal Health Care Workshop Classes
- ☐ MCU Neck Pain Therapy
- ☐ Massage Therapy

**PATIENT CONSENT:**I understand that there is a certain degrees of risk associated with chiropractic health care and physical rehabilitation therapy, which may include, but is not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms, fractures, disc injuries, strokes, and strain/sprains. I am willing to accept and consent to the risk associated with the care that I will receive.

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I understand treatments rendered by Better Health Pain & Wellness Centers, LLC are intended to aid in the reduction of my pain and that there is no guarantee or warranty for a specific cure or result.

**FINANCIAL POLICY:** If your carrier has not paid a claim within thirty (30) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within sixty (60) days of submission, you accept responsibility for payment in full of any outstanding balance.

**Auto Accident, Workers Compensation or Personal Injury Patients:**

BHPW will submit claims to your (or your employer if w/c) insurance carrier for payment and keep your private health insurance on file as secondary coverage; in the event of exhaustion or controversion of your claim. If you are involved in a 3rd party claim we will submit claims to the 3rd party carrier only when no other coverage is available. Once your claim becomes a 3rd party auto or your w/c claim is controverted, and after your active treatment plan, you become responsible for making monthly payments until account is paid in full. We understand that settlement of these cases may take time; however all auto accounts, workers compensation and personal injury cases must be paid in full within 12 months.

**Private/Group Health Insurance Patients:**
Until a "Customized Co-Pay Calculation Agreement" is signed, payment shall be made on each treatment date and applied toward deductible and/or co-pay as necessary. The pre-calculated co-payments are an estimate of your copay responsibility. Your actual portion may be more or less than the estimate, depending on services provided. Any additional information requested by insurance will be subject to a $35 processing fee, additionally, a special report will be $350 for the first page and $100 for each additional page (to be paid by insurance co.).

**Non-Covered (Cash/Self Pay) Patients:**
Payment in full is expected at the time of service or by an authorized payment plan.

Our fees are considered usual, customary, and reasonable by most companies and therefore, are usually covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

By signing below I understand and agree to the above conditions. I understand that I am responsible for all charges incurred at Better Health Pain and Wellness Centers, LLC and if I fail to make payments as arranged I will be subject to collection activity. I am responsible for any collection agency fees and interest of 10% annually incurred.

**ASSIGNMENT OF BENEFITS**: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

**RELEASE OF INFORMATION:** The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer. This documents may include, but are not limited to: Office notes, Physician notes, ER notes, Treatment plans, Diagnostic reports, Radiology/MRI films, Transcribed reports, Pathology reports, Consults, Admit/discharge records.

As a courtesy, we may send your primary care physician reports about your treatment with our office. By signing below, I authorize my records to be sent to my primary care physician and the release of any medical or other information necessary to process my claims. Our office may photograph you on your first visit for identification purposes. Your photograph may be sent to your insurance company with your medical records. Any other use will require your consent. Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Better Health Pain & Wellness Centers, LLC.

| | |
|---|---|
| **Printed Name of Patient or Legal Representative** | **DOB** |
| **Signature of Patient of Legal Representative** | **Date** |