Creekside Chiropractic

Automobile Crash Questionnaire

Date:_____

Name: _____

1. What is the date of the accident?_____
2. In your own words, please describe what happened. _____

   _____

   _____
3. What was your position in the vehicle at the time of the accident?

   - ❑ **Driver**
   - ❑ **Front Side Passenger**
   - ❑ **Left Rear Side Passenger**
   - ❑ **Right Rear Side Passenger**
4. What type of vehicle were you in? _____
5. How many other People were in the car with you?
   - ❑ **No one else**
   - ❑ **1**
   - ❑ **2**
   - ❑ **3**
   - ❑ **4**
   - ❑ **5**
   - ❑ **6**
6. What type of vehicle was the other party driving? _____
7. Were you wearing a seatbelt at the time of impact?
   - ❑ **Yes**
   - ❑ **No**
8. What was your vehicle doing at the time of impact?
   - ❑ **Moving**
   - ❑ **Stopped**
9. Were you prepared for the impact?
   - ❑ **Yes, I was prepared for the impact.**
   - ❑ **No, I was taken by surprise.**
10. How were you impacted?
    - ❑ **Head On**
    - ❑ **From the Rear**
    - ❑ **From the Left Side**
    - ❑ **From the Right Side**
    - ❑ **Obliquely from the Front Left Side**
    - ❑ **Obliquely from the Front Right Side**
    - ❑ **Obliquely from the Rear Left Side**
    - ❑ **Obliquely from the Rear Right Side**

[Turn Over]

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11. What was your body position during the impact?
    - ❑ **Head Straight**
    - ❑ **Head Turned Left**
    - ❑ **Head Turned Right**
    - ❑ **Torso Straight**
    - ❑ **Torso Turned Left**
    - ❑ **Torso Turned Right**

12. How would you describe the damage to your vehicle?
    - ❑ **Minimal**
    - ❑ **Moderate**
    - ❑ **Extensive**
    - ❑ **Totaled**
    - ❑ **Unsure**

13. Right after the crash, did you feel any of the following? (Check all that apply)
    - ❑ **Disoriented**
    - ❑ **Confused**
    - ❑ **Neck Pain**
    - ❑ **Upper back Pain**
    - ❑ **Mid Back Pain**
    - ❑ **Low Back Pain**
    - ❑ **Upper Extremity Pain**
    - ❑ **Lower Extremity Pain**

14. Were the police called to the scene?
    - ❑ **Yes**
    - ❑ **No**

15. Immediately after the accident, what did you do?
    - ❑ **Drove Home**
    - ❑ **Drove to Emergency Room**
    - ❑ **Was driven Home**
    - ❑ **Was driven to ER**
    - ❑ **Was driven away**

16. When did the symptoms you are experiencing now begin?
    - ❑ **Immediately**
    - ❑ **Shortly After**
    - ❑ **A Few Hours Later**
    - ❑ **The Next Day**
    - ❑ **A Few Days Later**
    - ❑ **A Week Later**
    - ❑ **A Couple of Weeks Later**

17. Any bruises or cuts from the accident?
    - ❑ **None**
    - ❑ **Minor**
    - ❑ **Significant**

18. Did you strike any of the following?
    - ❑ **Nothing**
    - ❑ **Steering Wheel**
    - ❑ **Dashboard**
    - ❑ **Windshield**
    - ❑ **Side Window**
    - ❑ **Back of Front Seat**
    - ❑ **Other**_____
      _____

[Turn Over]

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19. Have you sought any other medical treatment for your injuries?
    - ❑ **Yes**
    - ❑ **No**

20. If so, who have you seen?
    - ❑ **Medical Doctor**
    - ❑ **Chiropractor**
    - ❑ **Massage Therapist**
    - ❑ **Physical Therapist**
    - ❑ **Acupuncturist**
    - ❑ **Other**_____

    _____

21. Name and Location:_____

    _____

22. Name and Location:_____

    _____

23. Have you missed work because of this accident?
    - ❑ **Yes** *Please give dates:* _____
    - ❑ **No**

24. Have you retained an attorney?
    - ❑ **Yes**
        - Name: _____
        - Firm: _____
        - Phone Number: _____
    - ❑ **No**

Please sign to certify that the above information is true to the best of your knowledge.

X_____ ***Date:*** _____

Printed Name: _____

Relationship to Patient:_____

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New Patient History

Date:_____

Name:_____

Home Phone:_____ Cell Phone:_____

Social Security #:_____ Birthdate:_____ Age:_____

Email Address:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Please circle the best way to contact you: Email / Text / Home-Cell – Work Number

Occupation:_____ Employer:_____

Work Address:_____ Work Phone:_____

Marital Status:

- ❑ *Single*
- ❑ *Married*
- ❑ *Divorced*
- ❑ *Other*

Spouse's Name:_____ Children: 0 1 2 3 4 5+

Emergency contact name and number:_____

Who may we thank for referring you:_____

Insurance Information:

Is your condition due to:

- ❑ An Auto Accident
- ❑ A Personal Injury
- ❑ Work Injury

Health Insurance Company _____

Policy # _____

Spouse's Insurance Company _____

Policy # _____

Please sign here to authorization the release of records to your insurance carrier

X _____ Date: _____

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Please begin by letting us know what symptoms are giving you trouble.
Check all that apply.

1. Misc:
   - ❑ Headaches
   - ❑ TMJ

2. Spinal:
   - ❑ Neck Pain
   - ❑ Mid Back Pain
   - ❑ Low Back Pain
   - ❑ Neck Stiffness
   - ❑ Mid Back Stiffness
   - ❑ Low Back Stiffness

3. Upper:
   - ❑ Left Shoulder Pain
   - ❑ Right Shoulder Pain
   - ❑ Left Arm Pain
   - ❑ Right Arm Pain
   - ❑ Left Wrist Pain
   - ❑ Right Wrist Pain
   - ❑ Left Hand Pain
   - ❑ Right Hand Pain
   - ❑ Radiating Pain to the left Shoulder
   - ❑ Radiating Pain to the right Shoulder
   - ❑ Radiating Pain to the left Arm
   - ❑ Radiating Pain to the right Arm
   - ❑ *Numbness* and *Tingling* into the left Hand
   - ❑ *Numbness* and *Tingling* into the right Hand

4. Lower:
   - ❑ Back left hip pain
   - ❑ Back right hip pain
   - ❑ Left Hip Pain
   - ❑ Right Hip Pain
   - ❑ Left Leg Pain
   - ❑ Right Leg Pain
   - ❑ Left Knee Pain
   - ❑ Right Knee Pain
   - ❑ Left Foot Pain
   - ❑ Right Foot Pain
   - ❑ Radiating Pain into the left Buttocks
   - ❑ Radiating Pain into the right Buttocks
   - ❑ Radiating Pain into the left Leg
   - ❑ Radiating Pain into the right Leg
   - ❑ Radiating Pain into left Foot
   - ❑ Radiating Pain into right Foot
   - ❑ *Numbness* and *Tingling* into left Foot
   - ❑ *Numbness* and *Tingling* into right Foot

5. Other Symptoms: _____
   _____
   _____

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6. About when did your symptoms begin? _____

7. How did your symptoms begin?

- ❑ Not doing anything at the time of onset
- ❑ Motor Vehicle Accident
- ❑ Work Injury
- ❑ Overexertion
- ❑ Strenuous Position
- ❑ Fell
- ❑ Lifting
- ❑ Other_____
  _____

8. How soon did the symptoms come on?

- ❑ Immediately
- ❑ A week Later
- ❑ A Few Hours Later
- ❑ Slowly over time
- ❑ A few Days Later

9. What seems to **aggravate** your condition?

- ❑ Nothing
- ❑ Coughing
- ❑ Bending
- ❑ Lifting
- ❑ Walking
- ❑ Reaching
- ❑ Sitting
- ❑ Standing
- ❑ Pulling
- ❑ Turning
- ❑ Other:_____

10. What seems to **alleviate** your condition?

- ❑ Nothing
- ❑ Rest
- ❑ Sitting
- ❑ Stretching
- ❑ Exercise
- ❑ Standing
- ❑ Ice
- ❑ Heat
- ❑ Medication_____
- ❑ Other _____

11. How would you **characterize** your pain? *(Please check all that apply)*

- ❑ Burning
- ❑ Dull
- ❑ Sharp
- ❑ Shooting
- ❑ Aching
- ❑ Throbbing
- ❑ Other_____

12. Does your pain **radiate** to any o f the following areas?

- ❑ None
- ❑ Left Shoulder
- ❑ Right Shoulder
- ❑ Left Arm
- ❑ Right Arm
- ❑ Left Hand
- ❑ Right Hand
- ❑ Left Buttock
- ❑ Right Buttock
- ❑ Left Leg
- ❑ Right Leg
- ❑ Left Foot

- ❑ Right Foot
- ❑ Other_____

13. Are you experiencing any ***numbness* or *tingling***?

- ❑ None
- ❑ Left Shoulder
- ❑ Right shoulder
- ❑ Left Arm
- ❑ Right Arm
- ❑ Left Hand
- ❑ Right Hand
- ❑ Left buttocks
- ❑ Right Buttocks
- ❑ Left Leg
- ❑ Right Leg
- ❑ Left Foot
- ❑ Right Foot
- ❑ Other_____

14. Please rate your pain today on a scale of 0-10 (0= no pain and 10= your worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

15. At what time of day are your symptoms **worst**?

- ❑ None
- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ While Awake
- ❑ While Sleeping

16. At what time of day are your symptoms **best**?

- ❑ None
- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ While Awake
- ❑ While Sleeping

17. Have you seen anyone else for this condition?

- ❑ No
- ❑ Chiropractor
- ❑ MD
- ❑ Physical Therapist
- ❑ Specialist _____
- ❑ Other_____

18. Name and Location:_____

Name and Location:_____

19. What happened to your condition as a result of that treatment?

- ❑ Resolved
- ❑ Went Unresolved
- ❑ Improved but not to an Acceptable Level
- ❑ Worsened

20. Who is your primary? _____

MEDICAL HISTORY

21. Please list any allergies:_____

22. Do you have a history of any of the following? ❑ **Yes** ❑ **No**

❑ Work Injury ❑ Motor Vehicle Accident ❑ Slip and Fall Accident

23. If so, please list approximate dates and incidents of the injuries

1) Date:_____ Incident:_____
2) Date:_____ Incident:_____
3) Date:_____ Incident:_____
4) Date:_____ Incident:_____

24. Have you ever been hospitalized? ❑ **No** ❑ **Yes** If so. when and for what condition?

1) Date:_____ Condition:_____
2) Date:_____ Condition:_____
3) Date:_____ Condition:_____
4) Date:_____ Condition:_____

25. Have you had any surgeries? ❑ **No** ❑ **Yes** If so. when and for what surgery?

1) Date:_____ Surgery :_____
2) Date:_____ Surgery :_____
3) Date:_____ Surgery :_____
4) Date:_____ Surgery :_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

REVIEW OF SYSTEMS

Are you currently suffering from any of the problems below?

- ❑ General Fatigue
- ❑ Weakness Fever (continuous)
- ❑ Loss of Sleep
- ❑ Chills (continuous)
- ❑ Weight change
- ❑ Night sweats

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Convulsions
- ❑ Nervousness

- ❑ Anxiety
- ❑ Depression (prolonged)
- ❑ Phobias (excessive fears)
- ❑ Memory loss or impairment
- ❑ Mood swings (excessive)

- ❑ Hearing trouble
- ❑ Ringing in ears
- ❑ Pain in ears
- ❑ Ear discharge
- ❑ Vision trouble
- ❑ Pain in eyes
- ❑ Eye discharge

- ❑ Nose/sinus pain,
- ❑ Excessive drainage
- ❑ Nose bleeds (chronic)
- ❑ Nasal infections (chronic)
- ❑ Absence of smell

- ❑ Mouth sores,
- ❑ Bleeding gums
- ❑ Enlarged glands
- ❑ Absence of taste
- ❑ Abnormal taste sensation
- ❑ Tonsillitis/infected tonsils
- ❑ Difficulty swallowing

- ❑ Heat/cold intolerance
- ❑ Sugar in urine
- ❑ Goiter (enlarged thyroid gland)
- ❑ Tremor (shaking)

- ❑ Skin rash
- ❑ Redness of skin
- ❑ Skin itching
- ❑ Skin dryness
- ❑ Eczema (red/inflamed skin)
- ❑ Hair changes
- ❑ Nail changes
- ❑ Bruise easily

- ❑ Varicosities (visible veins)
- ❑ Blue extremities
- ❑ Swollen extremities
- ❑ Difficulty breathing
- ❑ Wheezing (chronic)
- ❑ Cough (chronic)
- ❑ Rapid heart beat
- ❑ Chest pain
- ❑ Heart palpitations
- ❑ Heart murmur

- ❑ Decreased appetite
- ❑ Increased appetite
- ❑ Abdominal pain
- ❑ Hemorrhoids
- ❑ Excessive gas
- ❑ Vomiting (excessive)
- ❑ Diarrhea (excessive)
- ❑ Constipation (excessive)
- ❑ Heartburn/indigestion

- ❑ Prostate problems
- ❑ Painful urination
- ❑ Inability to hold urine
- ❑ Frequent urination
- ❑ Bed-wetting
- ❑ Irregular menstruation
- ❑ Painful menstruation
- ❑ Abnormal vaginal bleeding
- ❑ Sterility

- ❑ Impotence
- ❑ Lumps in breast(s)
- ❑ Redness/itching of breast
- ❑ Dimpling of breast(s)
- ❑ Discharge from breast(s)
- ❑ Breast pain

Printed Name: _____ Relationship to Patient: _____

X_____ ***Date:***_____

(Please sign to certify that the above information is true to the best of your knowledge)

For Women Only

Date of your last menstrual period: _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? __

Do you suffer from PMS? _____

HIPPA (Health Insurance Portability & Health Care Information)

Re: Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Brown and his staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this is made by phone and you are not home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subjected to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvements or lack thereof may be discussed during your office visits.

This office videotapes and audiotapes doctor-patient communications and treatment in the treatment area. The tapes are used, generally, for training and quality assurance purposes. By signing this form, you are giving us permission to video and audiotape communications you have with any staff of Creekside Chiropractic.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This authorization will expire seven years after the date in which you last received services at Creekside Chiropractic.

I authorize Creekside Chiropractic to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature _____ **Date** _____

Name Printed _____

Authorization to Release Information to Physician

At Creekside Chiropractic we believe it is important that all of your physicians work together for your benefit. By signing this release you are authorizing us to release reports and information to your doctors regarding your treatment at Creekside Chiropractic.

Patient Signature _____ **Date** _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes cause by arterial dissections have been associated with over 72 every day activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headaches. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____Signature:_____ Date:

Parent or Guardian:_____ Signature:_____ Date:

Witness Name:_____Signature:_____ Date: