PALMER CHIROPRACTIC LIFE CENTER

AUTO ACCIDENT QUESTIONAIRE

TODAY'S DATE: _____

Name: _____

Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Cell Phone: _____Work Phone: _____

Email Address: _____

Gender: M / F Date of Birth: _____ Height: _____ Weight: _____

Race: (Circle One) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity: (Circle One) Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Preferred Language: _____

Marital Status (Circle One): Single / Married / Divorced / Separated / Widowed

Spouses Name: _____ Number of Children: _____

Have you ever been to a chiropractor before? (Circle one) Y or N

If Yes: Name: _____

Accident Information:

Please describe how the accident occurred: _____

_____

_____

_____

What was the date and time of the accident? Day:_____ Date: _____

Time: _____ am/pm State: _____

Where were you seated in the car? (Circle One) Driver's seat / Passenger seat / Back seat

Were you wearing a seatbelt? (Circle One) Y or N

Did the airbags deploy? (Circle One) Y or N

Was your head turned? (Circle One) Right / Left / Straight

Was your body turned? (Circle One) Right / Left / Straight

Were you aware of the accident before it happened (see it coming)? (Circle One) Y or N

What were the conditions of the road? (Circle One) Wet / Dry / Icy / Other: _____

Did any part of your body hit anything in the vehicle? (Circle One) Y or N

If yes, please describe: _____

Were you knocked unconscious? (Circle One) Y or N

Were your hands on the wheel? (Circle One) Both / Right / Left / None

What type of vehicle were you in? (Circle One) Car / Truck / SUV / Bus / Motorcycle / Bicycle

What was the vehicle damage to the vehicle? (Circle One) Light / Moderate / Heavy / Totaled

Were the police notified? (Circle One) Y or N

Did you go to the hospital? (Circle One) Y or N

If yes, did you get transported by ambulance? (Circle One) Y or N

Which hospital did you go to? _____

Were you treated anywhere else for this accident? (Circle One) Y or N

If yes, where and how long? _____

If yes, what did your treatment consist of? (i.e. X-rays, CT, MRI, etc.) _____

_____

Were you placed on any medications? (Circle One) Y or N

If yes, please list: _____

Is there anything else important that you want the doctor to know? _____

_____

MAJOR COMPLAINTS – Please check off areas of concern and complete the chart.

X		0-10 Pain Scale	**R**ight **L**eft **B**oth	**C**onstant **F**requent **O**ccasional	**X**		0-10 Pain Scale	**R**ight **L**eft **B**oth	**C**onstant **F**requent **O**ccasional
	Headache					Shoulder Pain			
	Neck Pain/Stiffness					Elbow Pain			
	Upper Back Pain					Wrist Pain			
	Mid Back Pain					Hip Pain			
	Low Back Pain					Knee Pain			
	Pins & Needles in Arm					Ankle Pain			
	Pins & Needles in Leg					Foot Pain			

- Others:_____

_____

When did your symptoms first appear?_____

Have you ever had the same or similar symptoms? (Circle One) Y or N

If yes, please explain: _____

What activities are difficult to perform due to this accident? (Check all that apply)

- Walking
- Bending
- Standing
- Sitting
- Lifting
- Driving
- Stretching
- Lying on side
- Lying on back
- Lying on stomach
- Turning head
- Turning body

Employment Information:

Regular Work Status: (Circle One) Full Time / Part Time / Homemaker / Unemployed

Employers Name: _____ Employer Phone #: _____

Employer Address: _____

Employer City: _____ State: _____ Zip Code: _____

Occupation: _____ Supervisor Name: _____

Supervisor Phone/Extension: _____

Physical Work Duties: (Circle One) Sedentary / Light / Medium / Heavy Labor

Explain:_____

_____

Have you missed any work due to your injuries? (Circle One) Y or N _____

Personal Health History

Name of Family Physician or Physician Seen: _____

Physician Phone: _____ Physician City: _____ State: _____

Have you had any of the following? (Circle all that apply)

Traumas / Recent weight loss / Surgeries / Allergies / Serious Illness (i.e. diabetes, arthritis, cancer, osteoporosis, high blood pressure, thyroid disorder, etc.)

If any apply, please explain (be specific):

_____

_____

_____

Are you taking any medications? (Please include regularly used over the counter medicines)

Medication Name	Dosage (i.e. 5mg)	Frequency (i.e. once a day)

Do you have any allergies to any medications? (Please be specific)

Medication Name	Reaction	Onset Date	Additional Comment

Do you take Blood Thinners? (Circle One) Yes or No

Have you ever:

Broken Bones? Y or N. Year? _____ Explain: _____

Been Hospitalized? Y or N. Year? _____ Explain: _____

Been in an Auto Accident? Y or N. Year? _____ Injuries? _____

Had Major Sprains/Strains? Y or N. Year? _____ Explain: _____

Had Surgery? Y or N. Year? _____ Explain: _____

Had a Stroke? Y or N. Year? _____

Smoked Cigarettes? Y or N. If yes, what date did you start? _____

How often? _____ Have you quit? Y or N. If yes, what date? _____

Consumed Alcohol? Y or N. If yes, How much? _____ How often? _____

Heart Conditions: (that may interact with certain therapy procedures)

Do you have a pacemaker or heart arrhythmia? (Circle One) Y or N

Do you have a defibrillator? (Circle One) Y or N

Females only:

Are you pregnant, or have you had any signs of pregnancy? (Circle One) Y or N

Are you planning to get pregnant in the next 12 months? (Circle One) Y or N

Automobile Insurance Information: (Your Automobile Insurance Information)

Insurance Company Name: _____

Insurance Company Phone Number: _____ Ext: _____

Insurance Adjustor: _____

Claim #: _____ Policy #:_____

Insured's Name: _____ Insured's Date of Birth: _____

Relationship: _____ Gender: (Circle One) M or F

Insured's Address: (If different from patient's) _____

Insured's City: _____ State: _____ Zip Code: _____

Attorney Information:

Name of Attorney and/or Firm: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Office Use Only:

Billing Name: _____

Billing Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Name of Adjustor: _____ Phone #: _____

Claim #: _____ Deductible? _____

Has deductible been met? Y or N / Has PIP been completed? Y or N / Date Verified: _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES PALMER CHIROPRACTIC LIFE CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- ❖ I give permission to Palmer Chiropractic Life Center to request/view copies of my medical records including but not limited to imaging reports, hospital records, notes from other treating physicians, and lab tests.
- ❖ Palmer Chiropractic may send information or records regarding my examination, treatment and diagnoses to my insurance company or attorney's office.
- ❖ I give Palmer Chiropractic Life Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for the conversations.
- ❖ By signing this form, you are giving Palmer Chiropractic Life Center permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Palmer Chiropractic Life Center. The written notice must contain the following information:

- Your name and date of birth; a clear statement of your intent to revoke this authorization; the date of your request and your signature.
- The revocation is not effective until it is received by the Privacy Official.
- This authorization is requested by Palmer Chiropractic Life Center for its own use/disclosure of protected health information.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Palmer Chiropractic Life Center will not refuse to provide treatment.

You have the right to inspect or copy the protected health information to be used/disclosed.

_____ _____

Date Signature of Patient

_____

Printed Name of Patient

Dr. T. Shane Palmer
Dr. Kimberly Mirra
191 Christiana Rd, Suite 1
New Castle, DE 19720
Phone: (302)328-2656 Fax: (302)328-5870

NOTICE OF DOCTOR'S LIEN

Patient's Name:_____ Date of Incident:_____

Attorney's Name:_____

I do hereby authorize **Palmer Chiropractic** to furnish my attorney named above with a full report of my examination, diagnosis, treatment, prognosis, etc., with regard to the incident in which I was recently injured.

I further authorize and direct my attorney to pay directly to **Palmer Chiropractic** such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctors.

I hereby further give a Lien on my case to **Palmer Chiropractic** against any and all proceeds of my settlement, judgement or verdict which may be recovered or paid as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by them for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any recovery made by me. I hereby agree to waive the defense of Statute of Limitations as it pertains to any claim filed against me beyond three years (or other statutory) after services were rendered. I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

I have been advised that if I do not wish to cooperate in protecting the doctor's interest by signing this document, the doctor will not await payment but may declare the entire balance due and payable at the time of service.

_____ _____

Date Patient's Signature

_____

Patient's Printed Name