

# PERSONAL INJURY INTRODUCTION FORM

Today's Date: \_\_\_\_\_

<b>Last Name:</b>		<b>First Name:</b>	<b>Middle Initial:</b>
<b>Mailing Address:</b>		<b>City:</b>	<b>State: Zip:</b>
<b>Date of Birth:</b>	<b>Age:</b>	<b>Social Security No:</b>	
<b>Height:</b>	<b>Weight:</b>	<b>Drivers License No:</b>	
<b>Occupation:</b>		<b>Marital Status (Circle):</b> Single, Married, Divorced, Widowed	
<b>Employer's Name:</b>		<b>Primary/ Current Treating Physician:</b>	
		<b>Phone number and/or address:</b>	

<input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the following telephone numbers: <input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the use of my name/address  Home: _____ Work _____  Cell: _____ Please star (*) your preferred phone number  E-mail Address: _____  I have read and understand my right to privacy, as stated to the right, and agree to have the practitioners and employees of CCPR maintain my records confidentially in accordance with the law. I agree to inform CCPR if I need to have any special arrangements pertaining to this issue.  Signature: _____ Date: _____	As a patient of Center for Chiropractic and Pain Rehabilitation (CCPR), you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the ways in which we secure your information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Notes taken during appointments are kept in your chart and secured in our clinic at all times. If patient charts are in public areas, the names are covered. Access to the clinic is limited to practitioners and employees. Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the clinic setting to protect your privacy and ensure that important information is kept in your chart. Your healthcare information is private and cannot be copied or shared with anyone else without your written signed consent. In some cases, verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied with a confidential patient information cover sheet is faxed. Our office needs to leave messages, return telephone calls, and send office mail to your mailing address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers to the left that are acceptable for our office to call.
---	--

**Emergency Contact :** \_\_\_\_\_ **Phone:** \_\_\_\_\_

## AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	<input type="checkbox"/> I have <input type="checkbox"/> Someone else has coverage. Indicate the name of the person that the policy is under:
How is this person related to you?	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	
Claim Number:	
Do you have an Insurance Deductible?	<input type="checkbox"/> Yes. <input type="checkbox"/> No Deductible is: \$
Do you know your Policy Limits for medical bills?	<input type="checkbox"/> Yes. <input type="checkbox"/> No Limit is: \$
Have you reported this injury to your insurance?	<input type="checkbox"/> Yes. <input type="checkbox"/> No
<input type="checkbox"/> Yes. <input type="checkbox"/> No. Do you have an attorney representing you? If yes, please fill out more info to the right	Attorney Name: _____ Telephone: _____

**AS A COURTESY, CCPR WILL BILL YOUR INSURANCE COMPANY. HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR THE BILL. UNTIL BENEFITS ARE CONFIRMED, A 30% CO-PAY WILL BE COLLECTED AT THE TIME OF SERVICE. WE EXPECT PAYMENT AT THE END OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR HEALTH INSURANCE PATIENTS.**

**MISSED APPOINTMENT POLICY:**

A 24-hour notice is required for all cancellations. A \$40 fee will be charged for all missed appointments. This fee will not be covered by your group, auto, or personal insurance. If we are closed, please leave a detailed message.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

As a patient at CCPR, I give the doctor of chiropractic (DC) permission and authority to care for me in accordance with the chiropractic tests, diagnosis and analysis s/he performs. The chiropractic adjustments and other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The DC will not provide treatment if s/he is aware of any contraindications. It is the responsibility of you the patient to make it known to the DC if you have any latent pathological defects, illnesses or deformities which would not otherwise be obvious to the DC. I understand that if I am accepted as a patient by a DC at CCPR, I am authorizing them to proceed with any treatment deemed to be necessary. The procedures, alternatives and risks involving the treatment will be explained to me prior to the treatment.

Patient Signature and Date	I am the responsible party. I agree to the above missed appointment and informed consent policies and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my insurance carrier.
----------------------------	--

# MOTOR VEHICLE COLLISION FORM (Page 1)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of collision: \_\_\_\_\_ Time of collision: \_\_\_\_\_  AM  PM  
 City where collision occurred: \_\_\_\_\_ Was the street wet or dry?  Wet  Dry  
 Street (location) where collision occurred: \_\_\_\_\_  
 Who owns the vehicle in which you were hit? \_\_\_\_\_  
 What is the estimated repair damage to your vehicle? \$ \_\_\_\_\_  Unknown,  Estimate not done yet  
 How many people were in your vehicle at the time of the collision? \_\_\_\_\_  
 Yes,  No Did the police come to the accident scene?  
 Yes,  No Did the police make a written report?  
 Yes,  No Were any photographs taken of the vehicles? If yes, who took them?

## DESCRIBE HOW THE COLLISION HAPPENED


## COLLISION DESCRIPTION-TYPE

*Check all that apply to you. Indicate which type of automobile collision you were involved in:*

<input type="checkbox"/> Single-vehicle collision	<input type="checkbox"/> Two-vehicle collision	<input type="checkbox"/> Three-or-more vehicles
<input type="checkbox"/> Rear-end collision	<input type="checkbox"/> Side collision	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on collision	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (Describe): _____		

## CIRCLE YOUR SEATING POSITION:

Front of Vehicle		
1	2	3
4	5	6
7	8	9
Rear of Vehicle		

## DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: \_\_\_\_\_  Unknown

## DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: \_\_\_\_\_  Unknown

## AT THE TIME OF IMPACT YOUR VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at a constant or steady speed

## AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other: _____

## DURING AND AFTER THE COLLISION, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object/curb other than car

## MOTOR VEHICLE COLLISION FORM (Page 2)

**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	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

**CHECK ANY OF THE FOLLOWING THAT WERE DAMAGED IN THE COLLISION:**

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat bent or damaged	<input type="checkbox"/> Dash or area around knee/foot
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side or rear window broken	<input type="checkbox"/> Other

Describe Damage:

**ALL TYPES OF COLLISIONS** (Please indicate those relevant to your case.)

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the collision?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door, dash, or interior of your vehicle touch or hit your body during the collision?
<input type="checkbox"/>	<input type="checkbox"/>	Did you strike or did any objects or animals within your vehicle hit you during the collision?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to a point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the collision? If yes, circle (side airbag/front airbag)
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any cuts, bruises, or abrasions from the airbag deploying?
<input type="checkbox"/>	<input type="checkbox"/>	Did your seatbelt system require repairs after the collision?
<input type="checkbox"/>	<input type="checkbox"/>	Was the seat that you were sitting in damaged or bent during the collision?
<input type="checkbox"/>	<input type="checkbox"/>	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

**SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:**

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have a: <input type="checkbox"/> Lap and Shoulder Strap <input type="checkbox"/> Automatic shoulder strap with driver needing to manually attach lap belt <input type="checkbox"/> Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any cuts, bruises, or abrasions from the seatbelts?
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned ( <i>Use time clock face as your reference point</i> ) Left hand: <input type="checkbox"/> Not on wheel <input type="checkbox"/> Yes, hand at ___ o'clock <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel <input type="checkbox"/> Yes, hand at ___ o'clock <input type="checkbox"/> Hand elsewhere

**REAR-END COLLISIONS ONLY:** (Answer this section only if you were hit from the rear.)

**Describe your vehicle's head restraint system:**

<input type="checkbox"/> Movable/adjustable head restraint	<input type="checkbox"/> Fixed, non-moveable head restraint
<input type="checkbox"/> No headrests in my vehicle	<input type="checkbox"/> Bench seat in your vehicle without head restraint

**Please indicate how your head restraint was positioned at the time of collision (if present):**

<input type="checkbox"/> At the top of the back of your head	<input type="checkbox"/> Midway height of the back of your head
<input type="checkbox"/> Lower height of the back of your head	<input type="checkbox"/> Located at the level of your neck
<input type="checkbox"/> Level of your shoulder blades	

# MOTOR VEHICLE COLLISION FORM (Page 3)

## BRUISING AFTER THE COLLISION?

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the collision? If yes, indicate where bruising was located on your body and what caused the bruising (if known):
--------------------------	--------------------------	---

### AWARENESS AND BODY POSITION DESCRIPTIONS: *Please check all areas that apply to you.*

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending collision and relaxed before the collision.
<input type="checkbox"/>	You were aware of the impending collision and braced yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left <input type="checkbox"/> Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
<input type="checkbox"/>	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
<input type="checkbox"/>	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

### HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

### PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

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

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Arm numb-tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg pain-numb-tingling	<input type="checkbox"/> Other Pain:	

### FRACTURES/BROKEN BONES HISTORY

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

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bones		<input type="checkbox"/> Leg or foot bones	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other: List	

### PREVIOUS SURGERIES

**( I have never had any surgical procedure).** If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Appendix or stomach	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

### ARE YOU TAKING ANY MEDICATIONS?

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

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Cortisone injections
<input type="checkbox"/> Pain/Anti-inflammatory meds	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Other:

# MOTOR VEHICLE COLLISION FORM (Page 4)

**HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE COLLISION?**

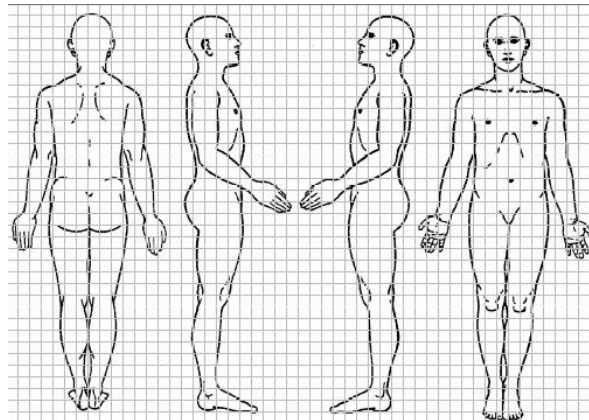
**LIST ALL SYMPTOM REGIONS RELATED TO YOUR MOTOR VEHICLE COLLISION**

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Knee/Ankle Pain	
<input type="checkbox"/> Shoulder/Elbow/Wrist Pain		<input type="checkbox"/> Dizziness/Vertigo	
<input type="checkbox"/> Jaw Pain		<input type="checkbox"/> Swelling/Stiffness of Joint(s)	
<input type="checkbox"/> Excessive Fatigue		<input type="checkbox"/> Other:	

**How severe is your pain?**    0    1    2    3    4    5    6    7    8    9    10  
No Pain Unbearable Pain

**SYMPTOM/PAIN DESCRIPTION** (Please circle any words/areas below that describe your current symptoms.)

Pain	Pinching	Spreading	Stiff or tight	Unbearable
Shooting	Soreness	Pulling	Sickening	Falls asleep
Ache	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Pressing	Radiating
Heavy	Nagging	Stinging	Deep pain	Weakness
Irritating	Burning-Hot	Dreadful	Superficial pain	Throbbing
Exhausting	Numbness	Torturing	Sharp	Tender



Please circle or mark with an **X** the areas where you have pain, numbness, tingling or other symptoms.

**WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?**

<input type="checkbox"/> Morning is when pain is worse	<input type="checkbox"/> Bending your back increases pain	<input type="checkbox"/> Walking increases pain
<input type="checkbox"/> Afternoon/evening pain worse	<input type="checkbox"/> Lying down flat increases pain	<input type="checkbox"/> Standing increases pain
<input type="checkbox"/> During sleep hours pain worse	<input type="checkbox"/> Sitting increases pain	<input type="checkbox"/> Exercise/Stretching increases pain
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Poor posture increases pain	<input type="checkbox"/> Other:

**WHAT ACTIVITIES LESSEN YOUR PAIN?**

<input type="checkbox"/> Walking	<input type="checkbox"/> Being flat on your back	<input type="checkbox"/> Exercise/Stretching
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other:

**DO YOU EXERCISE?**

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities

## MOTOR VEHICLE COLLISION FORM (Page 5)

*Check only those conditions that apply to you and indicate if you have had in the past or presently have.*

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	Heal slowly or Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or other neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Do you have any type of chest or breast implants presently (males &amp; females)?</b>	N/A	<input type="checkbox"/>
<input type="checkbox"/>	<b>Women only: Check box to left if there any chance that you are currently pregnant</b>		

No,  Yes Do you have any problems laying face down on an examination table? If yes, why: \_\_\_\_\_

### Have you ever been to a Chiropractor before for any condition?

No,  Yes If yes, Chiropractor's Name : \_\_\_\_\_ Year: \_\_\_\_\_

Problem(s) seen by Chiropractor for: \_\_\_\_\_