VEHICLE ACCIDENT REPORT

Name: _____ DOB: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____

Driver's license #: _____ Marital Status: _____

Occupation: _____ Email: _____

Nearest Relative – Name & Telephone: _____

Height: _____ Weight: _____ Race: _____ Date of accident: _____

Time of accident: _____

Were you: a) driver: _____ b) passenger – front: _____ c) passenger – rear: _____ d) number of passengers: _____

e) pedestrian: _____

Were you wearing a shoulder harness: Y / N Were you wearing a seatbelt: Y / N

Your vehicle: a) auto b) truck c) van d) motorcycle e) motorhome f) bicycle g) other

Year and model of your vehicle: _____

Owner of vehicle: _____ Approx. damage to the vehicle: $_____ Was it drivable: Y / N

Other vehicle: a) car b) truck c) van d) motorcycle e) motorhome f) bicycle g) other

Year and model of other vehicle: _____

Owner of vehicle: _____

Visibility at time of accident: ____ Poor ____ Fair ____Good

Road conditions at time of accident: ___ Dry ___Wet ___ Rainy ___Snow ___ Ice ___Fog ___ Clear ___Dark

How accident occurred: a) struck by another vehicle b) struck another vehicle c) struck stationary object d) other

Where was your vehicle hit: a) front b) rear c) front right side d) front left side e) rear right side

f) rear left side g) other

Other vehicle contact: a) front b) rear c) front right side d) front left side e) rear right side

f) rear left side g) other

In your own words, please describe the accident:

_____

_____

_____

_____

_____

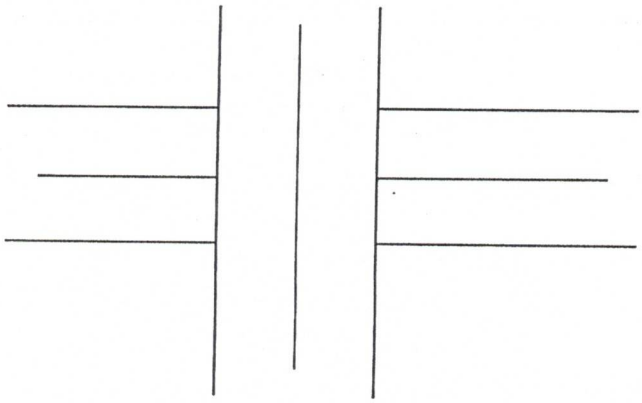
_____

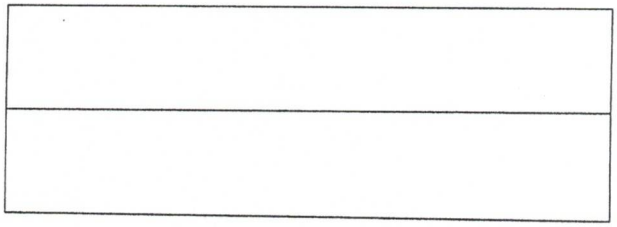
_____

_____

_____

INDICATE ON APPROPRIATE DIAGRAM HOW THE ACCIDENT HAPPENED:





Did you see the accident coming: Y / N Were you pre-warned that the accident was about to happen Y / N

Did you brace for impact: Y / N Does your car have headrests: Y / N

If yes, what was the position of those headrests compared to your head before the accident: a) top of headrest even with bott of head b) top of headrest even with top of head c) top of headrest even with middle of neck

Was the car you were in breaking: Y / N Your approx. speed: _____ Other vehicles approx. speed: _____

What was occurring at the moment of impact: (circle as many as apply)

a) tensed body for impact b) neck whipped forward and back c) spine torqued and twisted

d) thrown over seat e) thrown from vehicle f) pinned vehicle

g) thrown from side-to-side h) cut and bruised i) other: _____

What was your head position at the time of impact:

Head turned: ___ right ___ left ___ looking back ___pinned in vehicle.

Body rotated: ___ right ___ left

Did you strike your: (circle as many as apply)

a) Head against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

b) Shoulder against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

c) Arm against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

d) Elbow against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

e) Wrist against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

f) Hip against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

g) Knee against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

h) Ankle against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

Were you rendered unconscious: Y / N

Were you able to move all your body parts: Y / N If no, explain: _____

Were you able to get out of the car? Y / N If no, explain: _____

Did you bleed or get cuts and bruises: Y / N If yes, bleeding: _____ Cuts/bruises: _____

Were there any flying objects in the car: Y / N Where you hit: _____ Where: _____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

Circle symptoms you have noticed since the accident:

Headache	Dizziness	Light bothers eyes	Cold sweats
Neck pain	Head heavy	Loss of memory	Feet cold
Neck stiffness	Pins/Needles in arm	Ears ring	Hands cold
Sleeping problems	Pins/Needles in leg	Face Flush	Stomach upset
Numbness in fingers	Buzzing in ears	Constipation	Loss of taste
Mid-back pain	Nervousness	Loss of balance	Diarrhea
Low-back pain	Numbness in toes	Tension	Shortness of breath
Fainting	Fever	Loss of smell	Vomit
Irritability	Fatigue	Chest pain	Depression

Symptoms other than above: _____

Pain level: on a scale of 0-10, with 0 being pain free and fully functional, and 10 being constant agony and totally inability to function, where would you rate yourself: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Indicate ability to perform the following activities:

U – Unable P – Painful D – Difficult L – Limited N – Normal

__ Coughing or sneezing	__ Lying on side	__ Gripping	__ Climbing stairs
__ Getting in/out of car	__ Bending forward	__ Pushing	__ Bending to brush teeth
__ Pulling	__ Turning over in bed	__ Kneeling	__ Reaching
__ Walking short distance	__ Balancing	__ Sexual activity	__ Standing more than 1 hour
__ Dressing self	__ Stooping	__ Lying on back	__ Sleeping
__ Lying on stomach	__ Sitting at table	__ Other: _____	

Have you lost any time from work as a result of this accident: Y / N If yes, please complete below:

a) Last day worked: _____

b) Type of employment: _____

c) Are you being compensated for time from lost work: Y / N

Was a police report filed: Y / N

Did you receive medical attention at the time of the accident: Y / N

If yes, what was done: _____

Were you taken by ambulance to the hospital: Y / N If yes, where: _____

What was done: _____

What was the diagnosis give: _____

Where did you go immediately after the accident: a) resume activities b) home c) this office

d) Medical attention: Y / N If yes, where: _____ Were you examined: Y / N

e) Were you x-rayed: Y / N If yes, where: _____ What treatment was given: _____

f) Date of treatment: _____

Second doctor/clinic seen: _____ Date of visit: _____

a) Were you examined: Y / N b) Were you x-rayed: Y / N

c) Were you given treatment: Y / N If yes, explain: _____

d) What benefits did you receive from treatment: _____

e) Date of last treatment: _____

Did you have any physical complaint before the accident: Y / N If yes, please describe: _____

_____

_____

Have you ever been involved in an accident before: Y / N If yes, please describe and indicate date: _____

_____

_____

List surgical operation(s) and year(s): _____

_____

_____

_____

Medications you take now (circle all that apply):

None Nerve pills Pain killers Muscle Relaxers

Stimulant(s) Tranquilizers Insulin Birth Control

Other: _____

Do you smoke: Y / N Packs per day: _____ For how long: _____

Drink alcohol: Y / N Drinks per day: _____

Caffeine: Y / N Cups per day: _____

Exercise regularly: Y / N What exercises: _____

During the day (at work or home) do you: a) sit b) computer c) desk d) stand in one position

Lift more/less than 25 lbs. Explain: _____

Have you ever suffered from (circle all that apply):

Dizziness Backaches Heart trouble Diabetes Arthritis

Headaches Asthma Digestive Disorders Nervousness Sinus trouble Neck pain

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FAMILY MEDICAL HISTORY: Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders. Please list family member next to disorder:

High blood pressure: _____ Heart disease: _____

Cancer: _____ Diabetes: _____

Thyroid: _____ Kidney: _____

Arthritis: _____ Tuberculosis: _____

Stoke: _____ Lund disease: _____

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Date of birth: _____

Please list any medication(s) you are presently taking (including vitamins)

Medication	Dose	Reason

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFUL

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that is related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities and employee review activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, and law enforcement. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. **OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.** You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Print Name of patient _____ Signature of Patient or Guardian _____ Date _____

INFORMED CONSENT

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 called informed consent.

Chiropractic adjustments are the movement of bones with the doctor's hands or with the use of machines. Frequently, adjustments create a pop or click sound /sensation in the area being treated.

Stroke: Stroke is the most severe problem associated with chiropractic adjustments. Stroke means that a portion of the brain did not receive enough oxygen from the bloodstream. The result can be temporary or permanent dysfunction of the brain, with the rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is found inside the neck vertebrae. The adjustment that is related to a vertebral artery stroke is called the "extension-rotation-thrust adjustment." We do not do this adjustment on patients. Other types of neck adjustments may also be potentially related to vertebral artery strokes; but no one is certain. The most recent studies (Journal of the CCA-Vol. 37#2-June 1993) estimated that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before he would statistically be associated with a single stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerve, or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment adjustments, traction, etc. will aggravate the problem. Rarely surgery is required if the disc is in a weakened condition. This problem occurs so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine and middle back. They extend from the back to the front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only in patients who have very weakened bones from such things as osteoporosis. Osteoporosis can be noted on X-rays. We adjust all patients carefully and especially those who show osteoporosis on X-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These problems or complications occur so rarely that it is not possible to anticipate and/or explain them all 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 our best care; and if the results are not acceptable, we will refer you to another provider who we feel will assist in your situation. If you have any questions, please ask your doctor. When you have a full understanding of the risks, please sign and date below.

Print Patient's Name _____ Signature of patient or Guardian _____ Date _____

Medical Lien Disclosure

I understand that for the treatment provided by Capitol Chiropractic Wellness Center 1728 State Ave Ne Olympia, WA 98506 related to an automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as passenger, or struck by as a pedestrian/bicyclist. I understand Capitol Chiropractic will bill PIP and authorize the release of any information acquired in the course of my examinations and treatment in accordance with HIPAA privacy regulations. Payments are also accepted at the end of treatment or time of settlement.

Should PIP insurance not be available, exhaust or terminate for any reason, I authorize Capitol Chiropractic to hold my bills pending final claim resolution and file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien.

I acknowledge that I may be asked to make minimum monthly payments on any balances owed. Furthermore, If Capitol Chiropractic is to bill your health insurance you are responsible to notified Capitol Chiropractic prior to any treatment. If health insurance is billed, instead of PIP, please understand that some necessary treatments, that are injury related, are not covered and you will be responsible for payment.

Your Auto Insurance	Other Vehicle Insurance Information
Company: _____	Company: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Contact Name: _____	Contact Name: _____
Phone Number: _____	Phone Number: _____
Policy Holder: _____	Policy Holder: _____
Policy Number: _____	Policy Number: _____
Claim Number: _____	Claim Number: _____

_____ Print Patient's Name

_____ Signature of patient or Guardian

_____ Date