

DeCloedt Chiropractic
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(805) 581-2310
Auto Injury Information

Name _____ Today's Date _____
 Date of Accident _____ Time of Accident _____ AM PM
 Location of Accident _____
 Type of Accident: Auto/Traffic Work/On Job At Home Other _____
 Describe how the accident happened in your own words: _____

Name of Hospital: _____ Attended by Dr. _____
 Were you x-rayed at the hospital? Yes No If so, what was the diagnosis? _____
 Were you admitted to the hospital? Yes No How long did you stay? _____
 What treatment was rendered? _____
 What recommendations were made? _____
 List any other doctors you have seen as a result of this accident: _____

Have you lost any time from work because of this accident? Yes No If yes, give days of disability: _____
 Totally disabled from _____ to _____ Partially disabled from _____ to _____
 Have you returned to work since the accident? Yes No Were you wearing a seat belt? Yes No
 What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____
 If auto accident, were you the Driver Passenger Pedestrian?
 If passenger, were you sitting in the Front Right Rear Left Rear? Other? _____
 Did your vehicle hit other vehicle(s)? Yes No Estimated speed of your vehicle at impact? _____ MPH
 Was your vehicle hit by another vehicle(s)? Yes No Estimated speed of other vehicle at impact? _____ MPH
 Did your car strike the other(s) involved? Yes No or did the other car strike yours? Yes No Undetermined

VEHICLE YOU WERE IN:

Driver: _____
 Insured: _____
 Address: _____
 Phone: _____
 Auto Insurance Co.: _____
 Ins. Co. Address: _____
 Adjuster: _____
 Phone: _____
 Policy #: _____
 Claim #: _____

OTHER VEHICLE

Driver: _____
 Insured: _____
 Address: _____
 Phone: _____
 Auto Insurance Co.: _____
 Ins. Co. Address: _____
 Adjuster: _____
 Phone: _____
 Policy #: _____
 Claim #: _____

Did you require post-accident hospitalization? Yes No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & needles in Arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & needles in Legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____
 Have you lost days of work? YES NO Dates: _____
 Name of your Insurance Company involved: _____
 Name of person at your Insurance Company responsible for injuries: _____
 Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? YES NO
 Do you have an attorney who has advised you in this case? YES NO Name: _____
 Address of Attorney: _____ Phone No: _____
 Patient's Signature: _____ Date: _____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL

F – FREQUENT

C – CONSTANT

O F C

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
 - Painful tail bone
 - Poor posture
 - Sciatica
 - Spinal Curvature
 - Swollen joints

O F C

GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

O F C

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |

PLEASE PRINT

What's your major complaint? _____

List surgical operation and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers
 "Pep" pills Tranquilizers Birth control pills

Others: _____

Age of mattress: _____ Comfortable Uncomfortable Do you use a bed board? _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident: Past year Past five years Over five years Never

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:

Yes No

DESCRIBE BRIEFLY

- | | | | |
|--|--------------------------|--------------------------|-------|
| Been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Used a cane, crutch, or other support? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been treated for a spine or nerve disorder? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had a fractured bone? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been hospitalized for anything other than surgery? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

DO YOU:

- | | | | |
|--|--------------------------|--------------------------|-------|
| Now take vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Think you may need vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have an allergy to any drug? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

DATE OF LAST:

Less than 6 months

6-18 months

Over 18 months

Never

- | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Spinal examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest X- ray | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal X-ray | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental X-ray | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urine test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HABITS

Heavy

Moderate

Light

None

- | | | | | |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME _____

ADDRESS: _____ PHONE: _____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM
AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of California.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

_____ Date _____ Patient/Insured Signature _____

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to _____.

_____ Date _____ Patient/Insured Signature _____ Date _____ Staff Signature _____

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached [] pre-accident status or [] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Parent Signature _____ Date _____ Staff Signature _____