CAD Injury History Form

General information:

Patient's name: _____
Today's date: _____
Date of injury: _____
Marital status: M ☐ S☐ W☐ D☐
Habits:
Smoke: None☐ Pk/Day___ Years_____
Alcohol: Never☐ Social ☐ Light☐
Employment:
At the time of crash: _____
☐ Unemployed
Currently: _____
☐ Unemployed
Due to crash? ☐Yes ☐No
Type of work: ☐Office ☐Light labor
☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals):
_____
Fractures (dates and residuals):
_____
_____
Serious illness (dates and residuals):
_____
Workers' comp, injuries (date, treatments, awards, residuals):
_____
_____
Personal injuries (date, treatment, awards, residuals):
_____
_____
Sport or other injuries to head, neck or back: _____
_____

Current medical history:

Current health problems: ☐ None
_____
Current medications being taken: ☐ None
_____
_____

Past medical history:

Any prior history of current complaints;
_____
_____
Prior treatment by Chiropractor for these;
_____
_____

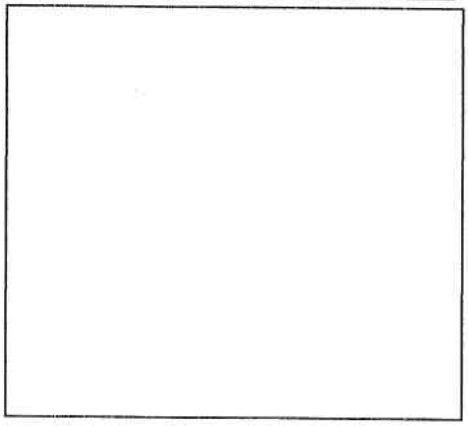
Injury, history and general:

Was the crash on-the-hob? ☐Yes ☐No
You were; ☐Driver ☐ Front passenger
☐ Rear passenger ☐Motorcycle driver
☐ Motorcycle passenger ☐ Other_____
Vehicle driven by: _____
Vehicle (year, make, and model):
_____
Estimated speed when crash occurred:
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, and model):
_____
Time of day when crash occurred:
☐Day ☐Dawn ☐Dusk ☐Night
Road conditions: ☐ Dry ☐ Damp ☐ Wet
☐ Snow ☐Ice Other:_____
Head rests in the vehicle you were in:
☐None ☐Non-adjustable ☐Adjustable
If adjustable, was the position altered by the crash? ☐Yes ☐No
Was your seat broken? ☐Yes ☐No
Seat belt: ☐Was wearing ☐Not wearing
Did the airbag deploy? ☐Yes ☐No
If yes, were you struck? ☐Yes ☐ No
Body position after accident:
☐Good ☐Forward lean
Other: _____
Head position after accident: ☐Forward
☐Left ☐Right ☐Up ☐Down
Crash Description:
_____
_____
_____

Crash Diagram:

Accident Location:

_____



Were you aware the crash was coming?
☐Yes ☐No

During the crash:

Did you strike any parts of the vehicle?
☐Yes ☐No If yes describe; _____

_____

Did the vehicle strike any objects? ☐No
If yes, describe: _____
Wearing hat or glasses? ☐Yes ☐No
If yes were they on after? ☐Yes ☐No
Did you loose consciousness ☐Yes ☐No
If yes, how long? _____
Estimated damage to your vehicle?
$_____
Estimated damage to the other vehicle?
☐None ☐Minimal ☐Moderate ☐Major
Were the police on the scene? ☐Yes ☐No
Was a police report made? ☐ Yes ☐No

After the crash;

Symptoms; ☐Headache ☐Dizziness
☐Nausea ☐Confusion/disorientation
☐Neck pain ☐Back pain
☐Extreme pain, where? _____
When did the symptoms first appear?
☐Immediately ☐ _____hours after
Where did you go after the crash?
☐Home ☐Work ☐Hospital

Emergency Department:

☐Didn't go to the hospital
X-rays: ☐No ☐Yes, which body parts?

_____
Results: _____
Lab work: ☐Yes ☐No
Cervical collar: ☐Yes ☐No
Medications: _____
Follow-up instructions: _____

_____

Treatment History for this accident:

☐Fitzpatrick Chiropractic clinic is the first location I have come to for treatment

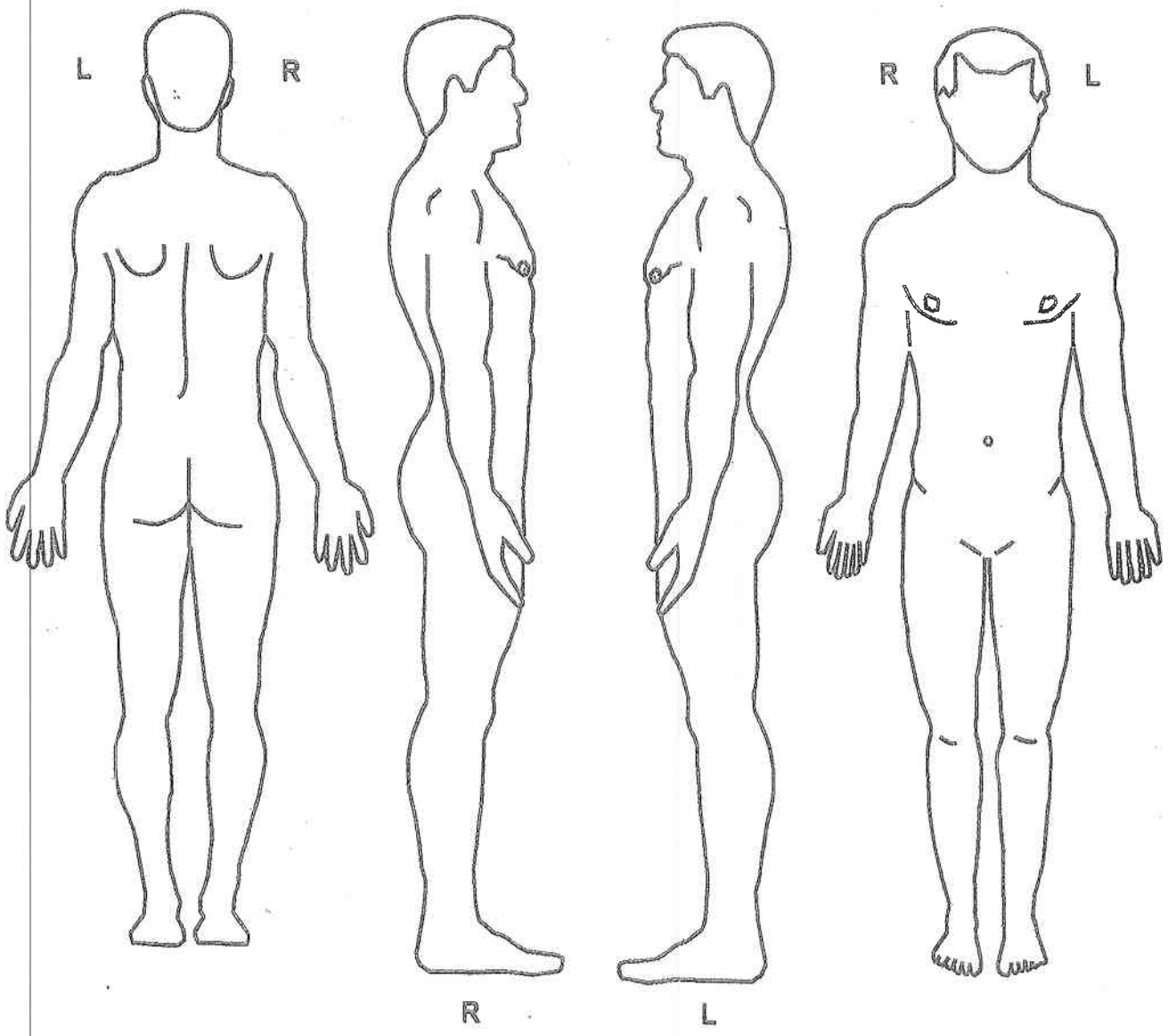
1. Dr._____
Specialty: _____
Treatment type: _____
Date first seen: _____
Currently treating ☐Yes ☐No
If yes, treatment frequency _____
Did treatment help ☐Yes ☐No
Notes: _____

2. Dr._____
Specialty: _____
Treatment type: _____
Date first seen: _____
Currently treating ☐Yes ☐No
If yes, treatment frequency _____
Did treatment help ☐Yes ☐No
Notes: _____

3. Dr._____
Specialty: _____
Treatment type: _____
Date first seen: _____
Currently treating ☐Yes ☐No
If yes, treatment frequency _____
Did treatment help ☐Yes ☐No
Notes: _____

PAIN DRAWING

Name _____ Date _____



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____

Neck Disability Index

Patient Name: _____ DOB: _____ Date: _____

Please read:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section **only the one box** which applies to you.

Pain intensity:
☐ I have no pain at the moment
☐ The pain is very mild
☐ The pain is moderate
☐ The pain is very severe
☐ The pain is the worst imaginable

Personal Care (Washing, dressing, etc):
☐ I can look after myself normally without extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself
☐ I need some help to manage personal care
☐ I need everyday help with personal care
☐ I do not get dressed/wash, staying in bed

Lifting:
☐ I can lift heavy weight without extra pain
☐ I can lift heavy weight but it causes pain
☐ Pain prevents me from lifting heavy things off the floor but I can manage if they're on a higher object, e.g. on a table
☐ Pain prevents me from lifting heavy weight
☐ I cannot lift or carry anything at all

Reading:
☐ I can read as much as I want to
☐ I can read but get a slight neck pain
☐ I can read but get moderate neck pain
☐ I cannot read because of moderate neck pain
☐ I can hardly read because severe neck pain
☐ I cannot read at all

Headaches:
☐ I have not had headaches
☐ I have slight headaches, infrequently
☐ I have moderate headaches, infrequently
☐ I have moderate headaches, frequently
☐ I have severe headaches, frequently
☐ I have headaches all the time

Concentration:
☐ I can concentrate with no difficulty
☐ I can concentrate with slight difficulty
☐ Its fairly difficult to concentrate
☐ I have a lot of difficulty concentrating
☐ I cannot concentrate at all

Work:
☐ I can work with no difficulty
☐ I can only do my basic work
☐ I can do most of my work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work
☐ I cannot work at all.

Driving:
☐ I can drive without neck pain
☐ I can drive with slight neck pain
☐ I can drive with moderate neck pain
☐ I can't drive for a long amount of time because of severe neck pain
☐ I can't drive at all because of pain

Sleeping:
☐ I have no trouble sleeping
☐ Sleep is slightly disturbed (1 hr or less)
☐ Sleep is mildly disturbed (1-2 hrs)
☐ Sleep is moderately disturbed (2-3 hrs)
☐ Sleep is greatly disturbed (3-5 hrs)
☐ Sleep is completely disturbed (5-7 hrs)

Recreation:
☐ I can partake in all activities with no pain
☐ I am able to engage in all activities with some pain
☐ I am able to engage in most activities but have some pain
☐ I can only partake in some activities
☐ I can hardly partake in activities
☐ I cannot partake in any activities because of pain

Low Back Pain Disability Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Please read:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section **only the one box** which applies to you.

Pain intensity:
☐ I have no pain at the moment
☐ The pain is very mild
☐ The pain is moderate
☐ The pain is very severe
☐ The pain is the worst imaginable

Personal Care (Washing, dressing, etc):
☐ I can look after myself normally without extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself
☐ I need some help to manage personal care
☐ I need everyday help with personal care
☐ I do not get dressed/wash, staying in bed

Lifting:
☐ I can lift heavy weight without extra pain
☐ I can lift heavy weight but it causes pain
☐ Pain prevents me from lifting heavy things off the floor but I can manage if they're on a higher object, e.g. on a table
☐ Pain prevents me from lifting heavy weight
☐ I cannot lift or carry anything at all

Walking:
☐ I can walk as much as I want to
☐ I can walk no more than 1 mile
☐ I can walk no more than ½ a mile
☐ I can barely walk ¼ of a mile
☐ I can only walk with a cane or crutches
☐ I am in bed most the time and cannot walk

Sitting:
☐ I can sit as long as I would like
☐ I can sit, with slight discomfort
☐ I can sit no more than 1 hour
☐ I cannot sit any longer than ½ an hour
☐ I cannot sit any longer than 10 minutes
☐ I cannot sit at all without severe pain

Standing:
☐ I can concentrate with no difficulty
☐ I can concentrate with slight difficulty
☐ Its fairly difficult to concentrate
☐ I have a lot of difficulty concentrating
☐ I cannot concentrate at all

Work:
☐ I can work with no difficulty
☐ I can only do my basic work
☐ I can do most of my work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work
☐ I cannot work at all.

Standing:
☐ I can stand without back pain
☐ I can stand with slight back pain
☐ I can stand with moderate back pain
☐ I can't stand for a long amount of time because of severe back pain
☐ I can't stand at all because of pain

Sleeping:
☐ I have no trouble sleeping
☐ Sleep is slightly disturbed (1 hr or less)
☐ Sleep is mildly disturbed (1-2 hrs)
☐ Sleep is moderately disturbed (2-3 hrs)
☐ Sleep is greatly disturbed (3-5 hrs)
☐ Sleep is completely disturbed (5-7 hrs)

Recreation:
☐ I can partake in all activities with no pain
☐ I am able to engage in all activities with some pain
☐ I am able to engage in most activities but have some pain
☐ I can only partake in some activities
☐ I can hardly partake in activities
☐ I cannot partake in any activities because of pain

Authorization and Assignment

Patient Name: _____

In consideration of your accepting my case, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any company, attorney or adjustor in order to process any claim for reimbursement of charges incurred for services rendered me by you or any member of your staff acting on your behalf.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise 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 to be correctly set forth under pertinent data below] and authorize you to persecute said action either in my name or your name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit.

I understand and agree at your discretion; Fitzpatrick Chiropractic may elect to forego billing an insurance carrier for services related to the accident in question until such time that I am making settlement arrangements, whereupon, an itemized statement will be submitted to the at-fault-party's carrier for payment of all charges that may have accrued relative to my care. However, it is understood that until all reasonable efforts have been made to collect the amounts owed directly from me. *I understand that whatever amounts you do not collect from insurance proceeds (whether is be all or part of what is due), I personally owe you.*

Date: _____ Signature: _____

Date of injury: _____

My personal Car Insurance
Company name: _____
Adjustor's name: _____
Adjustor's phone number:
_____
Policy #: _____
Claim #: _____

Car Insurance or responsible party
Responsible parties name:
_____
Insurance name: _____
Claims office Ph#: _____
Policy #: _____
Claim #: _____

Fitzpatrick Chiropractic Clinic

465 Rainier Blvd North
Issaquah, WA 98027
425-392-5321

Contractual guarantee of payment for medical services

I hereby authorize and direct you, my attorney, to pay directly to **Dr. James E. Fitzpatrick** such sums may be due and owing for health care services for injuries arising from a motor vehicle accident. I hereby authorize you, my attorney and involved insurance companies to withhold sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor or his office. I hereby further consent to lien being filed on my case by said doctor or his office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or me as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in event another attorney is substituted in this matter, the new attorney shall honor this contractual guarantee of payment for health care services as inherent in the settlement and enforceable upon the case as if it were execute by him/her.

I fully understand that I am directly and fully responsible to said doctor or his office for all health care bills submitted by him for services rendered to me. Further, this agreement is made solely for the said doctor's additional protection and in consideration of his forbearance on payment. I also understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover damages.

I specifically request my attorney to acknowledge this letter by signing below and retuning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

_____ _____

Date Signature

_____ _____

Patient's driver's license number Patient's social security number

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above, and agrees to withhold such terms from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor named above.

_____ _____

Date Signature of Attorney

Patient instruction and authorization to personal injury insurance carrier to make direct payment to chiropractor

I hearby authorize and instruct the following insurance carrier _____ to send, mail, all monies for diagnostic testing, treatment and or medical supplies to the following Doctor and Clinic.

Fitzpatrick Chiropractic Clinic: James E. Fitzpatrick, D.C.

Send and make all payment checks payable to:

Fitzpatrick Chiropractic Clinic 465 Rainier Blvd N. Issaquah, WA 98027

√	I authorize said Doctor to release any information pertinent to my case to the mentioned insurance carrier
√	A photocopy of this authorization shall be considered as valid as the original
√	I authorize said Doctor to use my name in the "Signature on file" in future billings
√	I authorize direct patient to the above doctor
√	I authorize use of this form on all my insurance submissions (billings)

Limited power of attorney for payment of chiropractic bills

I hearby, give limited power of attorney, for said Doctor and Clinic to cash and deposit any sums paid by the above insurance carrier for only the specific injuries indicated in this form.

Date: _____

Patient Name (Please print): _____

Signature of patient: _____

Date of injury: _____

Witness signature: _____