SNOHOMISH
Natural Health

Automobile Accident History

Date _____

Last _____ First _____ MI _____ Birthdate _____ Age _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ May we send you our email appointment reminders? ☐ Yes ☐ No

Occupation _____ Employer _____

Spouse's Name _____ Business/Employer _____ Spouse's Phone _____

Children's Names & Ages _____

Have you had previous Chiropractic care? ☐ Yes ☐ No Provider? _____

Who may we thank for referring you to our office? _____ ☐ Walk-in ☐ Facebook ☐ Website ☐ Insurance

Who is your primary care physician? _____ Address _____

Phone _____ Date of last physical/exam? _____ Provider? _____

Accident Information

Date of Accident _____ Time of Accident _____ am/pm ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road conditions at time of accident? ☐ Wet ☐ Dry ☐ Snow ☐ Ice ☐ Other _____

Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear-seat ☐ Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐ Aware ☐ Surprise

Did you lose consciousness upon impact? ☐ Yes ☐ No Did you experience a flash or light of explosion in your head? ☐ Yes ☐ No

Did the police come to the accident scene? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, did you receive any injury or bruise from the seat belt? ☐ Yes ☐ No

Did you hit your head rest during the accident? ☐ Yes ☐ No If adjustable, was the position of the head rest altered? ☐ Yes ☐ No

Was the seat adjustment altered by the accident? ☐ Yes ☐ No Was the seat broken by the accident? ☐ Yes ☐ No

Did the air-bag deploy? ☐ Yes ☐ No If yes, did it strike you? ☐ Yes ☐ No If yes, where? _____

Which way was your head pointing at the time of impact? ☐ Straight ☐ Right ☐ Left Your body? ☐ Straight ☐ Right ☐ Left

Where were your hands? ☐ One on the wheel ☐ Both on the wheel ☐ Not Applicable

Were you earing a hat or glasses at the time of impact? ☐ Yes ☐ No If so, were they still on after the accident? ☐ Yes ☐ No

Hospital/Follow-up Care

Did you go to the hospital? ☐ Yes ☐ No When? ☐ Immediately ☐ ____ hours later ☐ ____ days later Which hospital? _____

How did you get to the hospital? _____ How long did you stay in the hospital? _____

What did the hospital do for your injuries? (collar, splint, x-ray, medication, etc.) _____

What areas were x-rayed? _____ What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No If yes, please complete information below.

Doctor _____ Specialty _____ Date first seen _____
Type of treatment _____ Treatment frequency _____ Treatment length _____

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Type of treatment _____ Treatment frequency _____ Treatment length _____

Your Car

Description of car you were in: Year _____ Make _____ Model _____

Car speed at the time of impact? _____ MPH Was driver's foot on the brake? ☐ Yes ☐ No Was car stopped? ☐ Yes ☐ No

If vehicle was moving at the time of impact, was it: ☐ Slowing down ☐ Gaining speed ☐ Steady speed

The Other Car

Description of car you were in: Year _____ Make _____ Model _____

Car speed at the time of impact? _____ MPH Was driver's foot on the brake? ☐ Yes ☐ No Was car stopped? ☐ Yes ☐ No

At the time of impact, was the other car: ☐ Slowing down ☐ Gaining speed ☐ Steady speed

Automobile Insurance Information

Driver of the automobile you were in? _____ Name of their auto insurance? _____

Claim # _____

Auto Insurance Phone _____ Name of Insurance Adjuster _____

Driver of the other vehicle? _____ Name of their auto insurance? _____

Claim # _____

Auto Insurance Phone _____ Name of Insurance Adjuster _____

Accident Description

Please describe, to the best of your knowledge, what happened during the accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here.

At the time of the accident, did you experience any of the following:

☐ Confused ☐ Disoriented ☐ Light headed ☐ Dizzy ☐ Nauseated
☐ Blurred vision ☐ Ringing/Buzzing in ears ☐ Loss of Balance ☐ Other _____

Do you still have any of those symptoms? ☐ Yes ☐ No If yes, which ones? _____

Check symptoms you have noticed since the accident:

☐ Headaches/Migraines ☐ Neck Pain ☐ Upper Back Pain ☐ Shoulder Pain ☐ Midback Pain
☐ Low Back Pain ☐ Depression ☐ Buzzing in Ears ☐ Arm/Leg Pain ☐ Jaw Pain/Clicking
☐ Dizziness ☐ Fatigue ☐ Loss of Memory ☐ Cold Hands/Feet ☐ Numbness/Tingling
☐ Loss of Smell ☐ Irritability ☐ Digestive Problems ☐ Join Pain/Stiffness ☐ Menstrual Problems
☐ Pinched Nerve ☐ Loss of Sleep ☐ Loss of Balance ☐ Chest Pain ☐ Light Bothers Eyes
☐ Fever ☐ Nervousness ☐ Vision Problems ☐ Urinary Problems ☐ Sleeping Problems
☐ Paralysis ☐ Tension ☐ Fainting ☐ Pins/Needles Feeling ☐ Stomach Upset
☐ Difficulty Swallowing ☐ Sciatica ☐ Sinus Pain ☐ Sore Muscles ☐ Head Feels Too Heavy

☐ Other _____

Current Complaints? List current symptoms separately in order of severity.

First Body Part: _____

Date symptoms first appeared? _____

Frequency of symptoms? ☐ Constant 100% ☐ Frequent 75%
☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

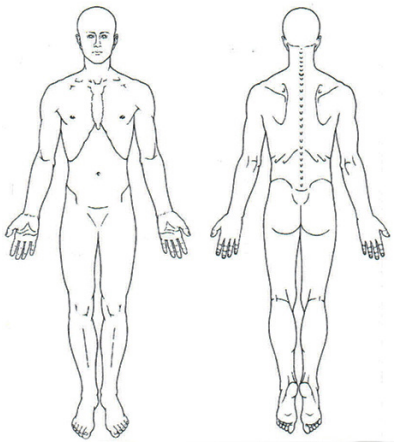
Type of Pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Numb ☐ Other _____

Please rate intensity of symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ○○○ 1 ○○○ 2 ○○○ 3 ○○○ 4 ○○○ 5 ○○○ 6 ○○○ 7 ○○○ 8 ○○○ 9 ○○○ 10

Where does pain radiate to? _____

Please mark areas of pain on the figure below.



Second Body Part: _____

Date symptoms first appeared? _____

Frequency of symptoms? ☐ Constant 100% ☐ Frequent 75%
☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

Type of Pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Numb ☐ Other _____

Please rate intensity of symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

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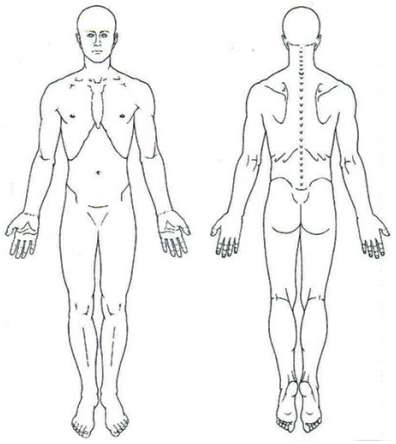

Third Body Part: _____

Date symptoms first appeared? _____

Frequency of symptoms? ☐ Constant 100% ☐ Frequent 75%
☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

Type of Pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Numb ☐ Other _____

Please rate intensity of symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

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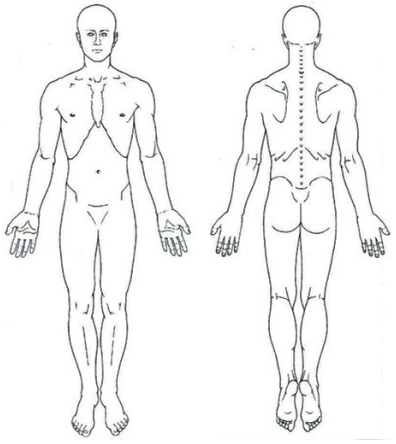

Occupational Information

Job involves: ☐ Sitting ☐ Standing How Long? _____ ☐ Lifting How Much? _____ ☐ Bending ☐ Twisting ☐ Turning ☐ Stooping
Physical activity at work: ☐ Sedentary ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor
Have you missed any time from work due to the accident? ☐ Yes ☐ No If yes, how many days? _____ Dates: _____
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No If yes, please explain: _____
Do any of your work activities aggravate your present main complaints? ☐ Yes ☐ No If yes, please explain: _____

Do you smoke? ☐ Yes ☐ No Packs per week? _____ Have you ever smoked in the past? ☐ Yes ☐ No When did you quit? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you consume caffeine? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week and what type? _____

Do you have a high stress level? ☐ Yes ☐ No If yes, list reasons: _____

Current Medications and Vitamins Taken

_____ Frequency: _____ Dosage: _____ What is it for? _____
_____ Frequency: _____ Dosage: _____ What is it for? _____
_____ Frequency: _____ Dosage: _____ What is it for? _____
_____ Frequency: _____ Dosage: _____ What is it for? _____

X-Ray Confirmation

Females: At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

Patient Signature _____ Date _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient Signature _____ Date _____

Authorization for Care of Minor

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at Snohomish Natural Health Chiropractic, PS and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print) _____

Name of Parent / Guardian (please print) _____

Patient / Guardian Signature _____ Date _____

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Notice Of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and/or copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number.

Our Notice of Privacy Practices describes in more detail how your health information may be used, disclosed, and how you can access your information.

By my signature below I acknowledge the receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature | Date

Printed name if signed on behalf of the patient (parent, legal guardian, personal representative.) | Relationship

Staff Notes:

This from will be retained in your medical record.

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PATIENT COPY —— FOR YOUR RECORDS

Date _____

Notice Of Patient Privacy

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As out patient, you have important rights relating to inspecting and coping your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosers of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and out obligations under law. We may revise out Notice from time to time. The effective date at the top right hand side of this page indicated the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office at 360-568-3319.

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of manual therapy and referral for diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure with the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I will have an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature of the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, mild to severe bruising or minor complications.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek
treatment.

I, _____ being the parent or legal guardian of _____
have read and full understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Patient/Parent/Guardian Signature Date