Back On Track Chiropractic & Massage

Scott W. Tromboni, DC
8621 Martin Way East, Suite A102
Lacey, WA. 98516
Telephone: (360) 456-4954
Fax: (360) 412-1227

Personal Injury Questionnaire

Name: _____ Social Security # _____
Address: _____City: _____ State: _____Zip:_____
Phone H: _____ Work: _____ Cell: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____ R/L Handed(Circle)
Occupation: _____ Company Name: _____
Job Location: _____
Please check one: ___Single ___Married ___Divorced ___Separated ___Widowed
Spouse's Name: _____
In event of an emergency, is there someone that we should contact?
Name _____ Relationship _____ Phone _____
Who referred you to our clinic:_____

Your Insurance Co: _____ Claim #: _____
Driver/Other Vehicle: _____ Ins. Co. _____ Claim#: _____
Have you retained an attorney? ___No ___Yes Name: _____
Adjusters name: _____ Phone number: _____
Is there a police report? Y / N Do you have personal injury protection Y / N

Accident Information:

1. Date of Accident? _____ Time of Day? _____()AM ()PM
2. Were you: (Check One) ___Driver ___Passenger ___Front Seat ___Back Seat
3. Number of people in your vehicle? _____ # of people in other vehicle? _____
4. Road conditions at accident? ___Wet ___Dry ___Icy ___Other_____
   Road surface? ___Asphalt ___Gravel ___Dirt ___Other_____
5. What direction were you headed? ()N ()S ()E ()W
   Name of street or hi-way?_____
6. Other car direction? ()N ()S ()E ()W
   Name of street or hi-way? _____
7. Were you struck from : ___Behind ___Front ___Left side ___Right side
8. Were you wearing a seat belt? ( )No ( )Yes If yes-( ) Lap belt ( )Shoulder belt ( ) Both
   Any bruising or soreness from belt? ( )No ( )Yes if yes explain _____
   _____
9. Did airbags activate? ( )No ( )Yes
   Any bruising or soreness from the airbag? ( ) No ( ) Yes if yes, explain _____
   _____
10. Position at time of impact? ___Facing ahead ___Head turned ___Right ___Left

11. Does your car have a headrest? ( )No ( )Yes If yes, about how far was the top of the headrest from the top of your head? _____inches ( ) above ( ) below
12. Were you knocked unconscious? ( )No ( )Yes If yes, for how long _____
13. Were you aware of approaching impact? ( )No ( )Yes ( )Surprised
    If yes, did you brace for impact? ( )No ( )Yes, how _____
14. Was your car stopped at time of impact? ( )Yes ( )No
    If yes, was driver's foot on the brake pedal? ( )Yes ( )No
    on the Clutch pedal? ( )Yes ( )No
    If yes, did your car move forward on impact? ( )Yes ( )No
    If car was moving at the time of impact were you (check one)
    ___gaining speed ___slowing down ___traveling at steady speed.
15. What was your approximate speed? _____ miles per hour
16. Did your vehicle hit a second car? ( ) No ( )Yes
    Another object? ( )No ( ) Yes Explain _____
17. Was the other vehicle moving at time of collision? ( )No ( )Yes
    If yes, how fast was the other vehicle traveling? _____miles per hour
    If yes, was the other vehicle? (check one)
    ___gaining speed ___slowing down ___traveling steadily
18. What type/make of car were you driving?
    _____
19. What type/make of car impacted you?
    _____
20. In your own words, please describe the accident, include what you heard, saw or felt.
    _____
    _____
    _____
    _____
    _____
21. Please describe how you felt. Did you feel pain?
    a. DURING the accident? _____
    _____
    b. IMMEDIATELY AFTER the accident?_____
    _____
    c. LATER THAT DAY? _____
    _____
    d. THE NEXT DAY? _____
    _____
22. Estimated cost of damage to your vehicle? _____
    Do you have a photo showing damage? ( )Yes ( )No

23. CIRCLE which of the following body parts were hit/injured during the accident.

a. Head hit	e. R/L hip hit
b. Chest hit	f. R/L leg hit
c. R/L shoulder hit	g. R/L knee hit
d. R/L arm hit	h. Other _____

24. CIRCLE which of the following car parts were damaged during the accident.
    a. Windshield
    b. R/L side window
    c. Steering wheel
    d. Front seat
    e. Other _____
    f. Other _____

25. Did you have any physical complaints **BEFORE THE ACCIDENT**? ( ) No ( )Yes,
    If yes, describe in detail. _____
    _____
    _____

26. Do you have any congenital (from birth) factor which relates to this problem?
    ( )No ( ) Yes, If yes, explain._____
    _____

27. Do you have any previous illnesses relating to this case: ( ) No ( ) Yes,
    If yes, explain _____

28. Have you ever been involved in an accident before: ( ) No ( )Yes
    If yes, describe including dates, type of accident, and injury(s) received.
    _____
    _____

29. Did you receive **emergency care IMMEDIATELY** following this accident?
    ( ) No ( )Yes, If yes, where, type of treatment, doctor's name?_____
    _____
    _____

30. Have you been treated by another doctor since the accident? ( ) No ( )Yes
    If yes, list doctor's name and treatment:_____
    _____

31. Since this injury occurred, are symptoms: ___ Improving ___Getting worse ___Same

32. Circle the symptoms that you have noticed **since** the accident:

Headache	Shoulder Pain	Loss of Smell	Sleeping Problems	Rib Pain
Neck Pain	Elbow Pain	Dizziness	Head Seems Heavy	Face Flushing
Neck Stiffness	Wrist Pain	Fainting	Pins/Needles in Arms	Cold Sweats
Upper Back Pain	Arm Pain	Fever	Pins/Needles in Legs	Depression
Mid Back Pain	Leg Pain	Ears Ring	Numbness in Fingers	Nervousness
Low Back Pain	Chest Pain	Irritability	Numbness in Toes	Feet Cold
Hip Pain	Loss of Taste	Fatigue	Shortness of Breath	Hands Cold
Knee Pain	Loss of Memory	Diarrhea	Lights Bother Eyes	Foot Pain

Any Symptoms not listed? _____
_____
_____

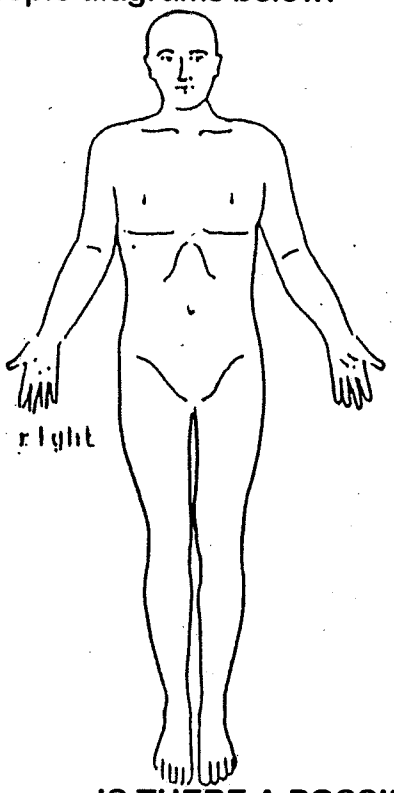
33. Have you lost time from work as a result of the accident: ( ) No ( ) Yes
    If yes, when were you off from work? From _____ to _____
    Are you being compensated for lost time? ( ) No ( ) Yes, Medical release ( ) No ( ) Yes

34. Since the accident do you notice any activity restrictions in your capacity for:
Work? ( ) No ( )Yes explain _____
_____
Family? ( ) No ( ) Yes explain _____
Recreation?: ( ) No ( ) Yes explain _____
_____

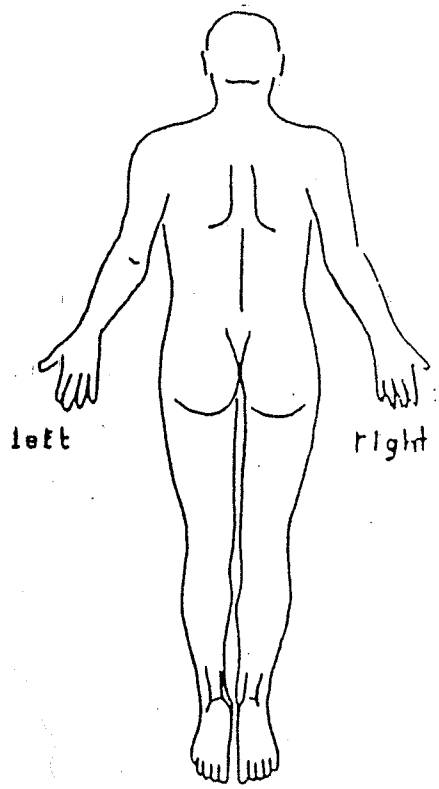
35. Other pertinent information?_____
_____
_____

COMPLETE THE FOLLOWING:

36. Please fill in current complaint areas by placing the appropriate abbreviated letter on the people diagrams below:



P=Pain
B=Burning
S=Stiffness
T=Tingling
N=Numbness



IS THERE A POSSIBILITY YOU MAY BE PREGNANT? ___YES ___NO

The above information is true and correct to the best of my knowledge, I accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time X-rays, examinations, and adjustments are received, unless other arrangements are made in advance. I hereby authorize Back On Track Chiropractic Center to release any information related to this claim to insurance companies, attorneys or collection agencies if necessary.

_____ _____
PATIENT'S SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Back On Track Chiropractic & Massage
8621 Martin Way E. #A102
Lacey, WA 98516

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ **Date:**_____

Relationship to Patient: _____ **Authorized persons?** _____

Signature: _____

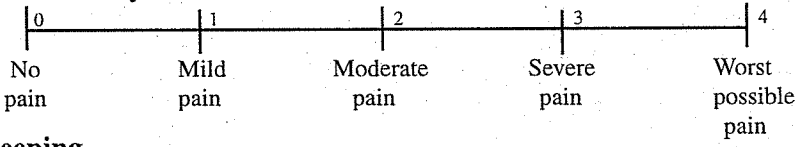
If for some reason we are not able to contact you, can we leave a message in regards to your appointment? Y / N
If so, at what number and with whom? _____

Functional Rating Index

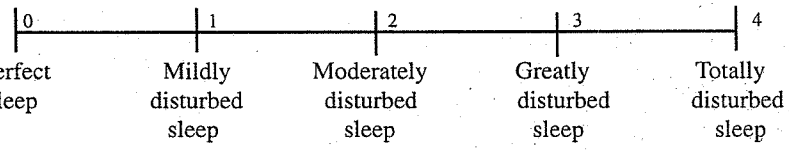
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

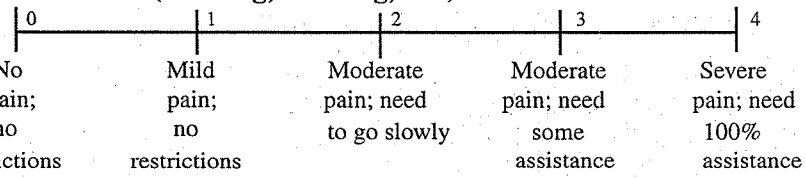
1. Pain Intensity



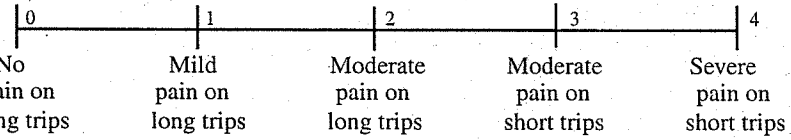
2. Sleeping



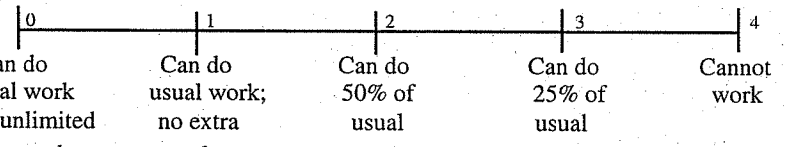
3. Personal Care (washing, dressing, etc.)



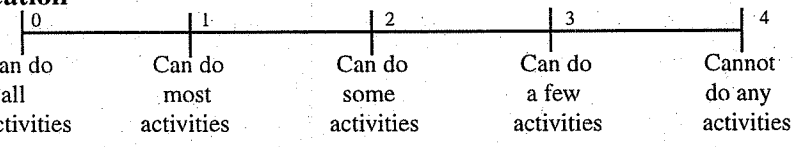
4. Travel (driving, etc.)



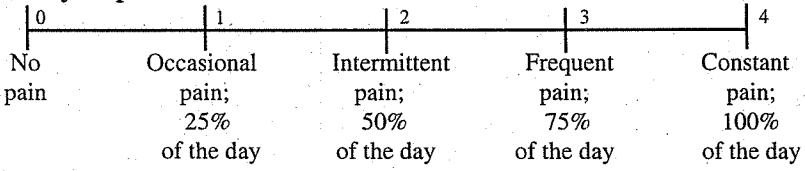
5. Work



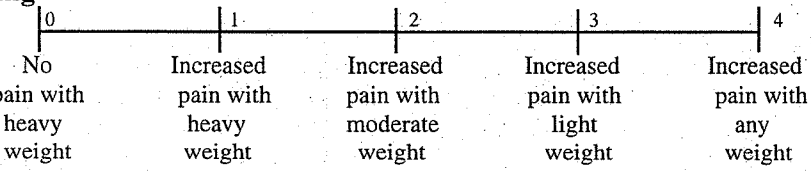
6. Recreation



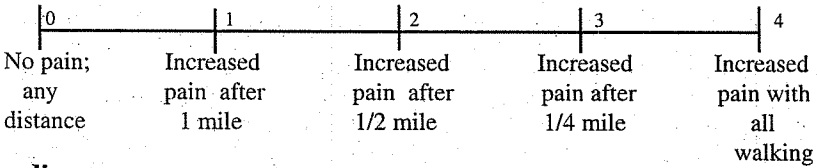
7. Frequency of pain



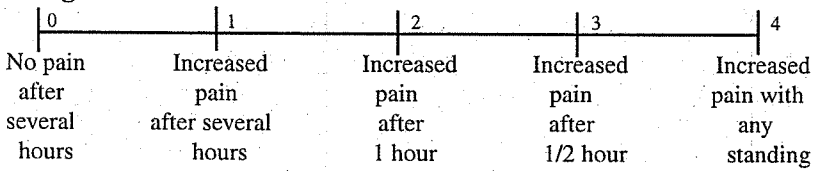
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: