

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and 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. In order for us to understand you condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Marital Date of

Name: _____ Sex: _____ Status: _____ Birth: _____
 _____/_____/_____

Mailing Address: _____ City: _____ ST: _____
 _____ Zip: _____

S. S. #: _____ Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Please explain in detail how your accident happened

	Driver of vehicle in which you where injured	At-Fault Driver
Insured's Name and Policy #		
Insurance Company		
Insurance Company Address		
Adjuster Phone		
Claim #		

Have you retained an attorney? YES NO If so, his/her name and phone:

Were police notified? YES NO Were you knocked unconscious? YES NO

NO

You were: Driver Passenger Front Seat Back Seat Wearing Seat Belts

Other Protective Devices

What was the time and date of present injury?

Where did you feel pain immediately after the accident?

Where were you taken after the accident? _____ What treatment was given?

Was any other doctor consulted after the accident? YES NO If so, Who

What was the diagnosis given? _____ What treatment was given?

How often did you see the doctor? _____ How long did you see the doctor?

Have you ever had any complaints in the involved area before? YES NO

If so, the complaints?

Before the accident were you capable of working on an equal basis with others your age?

YES NO

Are your work activities restricted as a result of this accident? YES NO

Since this injury are your symptoms Improving Getting Worse Same

Signature: _____ Date:

HEALTH QUESTIONNAIRE

Patient Name: _____ Date:

Musculo-Skeletal System

Genito-Urinary System

Gastro-Intestinal System

Cardio-Vascular-

Respiratory

___ Low Back Problems

___ Bladder Trouble

___ Poor Appetite

___ Pain Between Shoulders

___ Excessive Urine

___ Excessive Hunger

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Scanty Urination | <input type="checkbox"/> Difficult Chewing |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Difficult Swallowing |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Coughing Phlegm | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Vomiting Food |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Vomiting Blood |
| <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> B. P. Problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Lung Problems | |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Varicose Veins | |

Female

- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Lumps on Breast

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
 B = BURNING
 S = STABBING
 N = NUMBNESS
 P = PINS & NEEDLES

Eye, Ear Nose &

Throat

- Eye Strain

- Black Stool
- Bloody Stool
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble

Eye Inflammation

Vision Problems

Ear Pain

Ear Noises

Hearing Loss

Ear Discharge

Nose Pain

Nose Bleeding

Difficulty Breathing

Through Nose

Sore Gums

Hoarseness

Difficult Speech

Nervous System

Numbness

Paralysis

Dizziness

Fainting

Headaches

Muscle Jerking

Convulsions

Depression

Childhood Diseases:

—

Health Complications:

Medication Presently Taking:

Prior Surgery:

Previous Accidents:

—

Mother living? Y / N

In Good Health? Y / N

Father living? Y / N

In Good Health Y / N

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and 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 treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Print Patient Name: _____ Date:

Signature of Patient:

—
Signature of Legal Gaurdian (if patient is minor):

Print Name:

River Parishes Chiropractic
River Parishes Chiropractic
1108 W. Airline Hwy
1959 Hwy. 3125
LaPlace, LA 70068
Lutcher, LA 70071

Treating Physician(s):

Robert Dale, D. C. Physician

Date

J. Kevin Martin, D. C.

Dwayne Burch, D.C.

Witness _____ Date _____

Doctor's Lien

I, the undersigned, understand that all past, present and future bills incurred at River Parishes Chiropractic, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

In consideration for River Parishes Chiropractic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/ injury/ illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict, or result of said accident/ injury/ illness and I judgment related to this accident/ injury/ illness.

I also understand that if the settlement does not cover my entire bill at this clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim, or judgment, which I may eventually recover.

Furthermore, in consideration for River Parishes Chiropractic refraining from

attempting to collect immediate payment for services rendered for my accident/ injury/ illness, I do hereby waive and toll any applicable statute of limitation on the collection of my account until I notify River Parishes Chiropractic of the conclusion of my efforts to obtain a settlement of judgment through the assistance of my attorney and for a period of three (3) months thereafter.

Patient Name (Please Print) Patient Signature
Date

Instructions To Counsel

I do hereby instruct you, my Attorney, named below, to pay River Parishes Chiropractic in full for services to me for my accident/ injury/ illness from any proceeds of settlement, claim, or judgment regarding said accident/ injury/ illness. You are to pay River Parishes Chiropractic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/ injury/ illness, which I have agreed to pay in full.

Firm Name Patient Signature

Attorney Name Date

Attorney's Acceptance Of Lien

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

Attorney Signature Date

River Parishes Chiropractic
Patient Consent For Protected Health Information To Carry Out

Treatment, Payment and Health Care Operations

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

- 1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and / or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice has explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my rights to obtain a copy of the Privacy Notice Prior to signing this consent.
- 2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 3) I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine to with the person answering the phone.
- 4) The Practice may use and / or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
- 5) I understand that I have the right to request that the Practice restrict how my PHI is used and / or disclosed to carry out treatment, payment, and / or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
- 6) I understand that this consent is valid for seven years. I further understand that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent
- 7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
- 8) I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice may not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient Name (Please Print)
Date

Patient Signature