

Motor Vehicle Collision Questionnaire

Patient # _____

(Circle) Dr. D; Dr. S; Dr. A

Patient Name: _____

Date: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Social Security # _____

Occupation _____

Employer _____

(If retired, previous occupation)

Have you ever received Chiropractic/Acupuncture Care? Yes No If yes, when? _____

Name of most recent Chiropractor/Acupuncturist: _____

1. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

2. Since the Motor Vehicle Collision, have you experienced any of the following:

- A. Loss of Range of Motion: yes/no
 - a. What body parts: _____
- B. Visual Disturbance : yes/no (please explain): _____
- C. Dizziness: yes/no How often: _____
- D. Anxiety: yes/no How often: _____
- E. Depression: yes/no How often: _____
- F. Difficulty Sleeping: yes/no How often: _____

3. Past Health History:

A. Previous illnesses you've had in your life:

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

C. Allergies:

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

4. Family Health History:

Associated health problems of relatives:

Deaths in immediate family:

Cause of parents or siblings death	Age at death

5. Social and Occupational History:

A. Job description:

B. Work schedule:

C. Recreational activities:

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to [doctor's name/clinic name] for services performed.

Patient or Guardian Signature _____

Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Signature of AHC Witness

Printed Name

Date

Appointment Reminders and Health Care Information Authorization

Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health-related information at any time (§164.520).

This notice is effective as of the date this form was signed below. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that, if requested, I will receive a copy of this authorization.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Name Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - Did you have this symptom before this motor vehicle collision? Yes/No
 - If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - Did you have this symptom before this motor vehicle collision? Yes/No
 - If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - Did you have this symptom before this motor vehicle collision? Yes/No
 - If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
 - Did you have this symptom before this motor vehicle collision? Yes/No
 - If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Angle of Impact: **Front / Back / Left / Right / Other:** _____

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other:** _____

1) In relation to the back of your head, was your headrest set: **Low / Middle / High**

2) Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

3b) Were you leaning forward at the time of impact? **Yes / No**

4) What type and year of vehicle were you in? _____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type and year of vehicle struck yours? _____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

7) Did you feel pain immediately after the accident? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** _____

Patient Name: _____

Date: _____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom?

Did you go to the hospital? **Yes / No** If "YES", when?

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long?

Name of Hospital? _____ Attended by Dr.

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches /
Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed
Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an
Orthopedist / Instructed to Call a Private Physician / Referred to This Office /
Other: _____**

What other doctor have you seen as a result of this injury?

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

Symptoms other than above:

Patient Signature

Date

Patient Name: _____

Date: _____

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work Reason for the difficulty Duration

Job Description: _____

- Lifting Increased Pain _____
- Bending Increased Pain _____
- Sitting Increased Pain _____
- Walking Increased Pain _____
- Computer Duties Increased Pain _____
- Other: _____ Increased Pain _____

Studies/School Reason for the difficulty Duration

- Lifting Increased Pain _____
- Bending Increased Pain _____
- Sitting Increased Pain _____
- Walking Increased Pain _____
- Computer Duties Increased Pain _____
- Studying Increased Pain _____
- Other: _____ Increased Pain _____

Domestic Duties Reason for the difficulty Duration

- Vacuuming Increased Pain _____
- Taking Care of Kids Increased Anxiety _____
- Cleaning Increased Pain _____
- Preparing Meals Increased Pain _____
- Other: _____ Increased Pain _____

Household Duties Reason for the difficulty Duration

- Yardwork Increased Pain _____
- Transportation Increased Anxiety _____
- Shopping Increased Pain _____
- Taking Out Trash Increased Pain _____
- Other: _____ Increased Pain _____

Patient Name: _____

Date: _____

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work Reason for the difficulty Duration

Job Description: _____

- Lifting Increased Pain _____
- Bending Increased Pain _____
- Sitting Increased Pain _____
- Walking Increased Pain _____
- Computer Duties Increased Pain _____
- Other: _____ Increased Pain _____

Studies/School Reason for the difficulty Duration

- Lifting Increased Pain _____
- Bending Increased Pain _____
- Sitting Increased Pain _____
- Walking Increased Pain _____
- Computer Duties Increased Pain _____
- Studying Increased Pain _____
- Other: _____ Increased Pain _____

Domestic Duties Reason for the difficulty Duration

- Vacuuming Increased Pain _____
- Taking Care of Kids Increased Anxiety _____
- Cleaning Increased Pain _____
- Preparing Meals Increased Pain _____
- Other: _____ Increased Pain _____

Household Duties Reason for the difficulty Duration

- Yardwork Increased Pain _____
- Transportation Increased Anxiety _____
- Shopping Increased Pain _____
- Taking Out Trash Increased Pain _____
- Other: _____ Increased Pain _____

Sports Reason for the difficulty Duration

- Social _____
- Competitive _____
- Regional _____
- Other: _____

Alternative Health Clinic

4810 N. Kings Highway • Myrtle Beach, SC 29577 • (843) 692-9243

CONFIDENTIAL PATIENT CARD

I.D.N.S.: _____

Name _____
(Ms. Mrs. Mr.) _____ Sex: M / F SS# _____ - _____ - _____

Street _____ City _____ State _____ ZIP _____

Home Phone () _____ Age: _____ Date of Birth: _____

Height _____ Weight _____ lbs. E-Mail: _____

Occupation _____ Business Phone () _____

WHERE DO YOU HURT? CHECK SYMPTOMS YOU ARE HAVING

- | | | |
|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Constipation - BM / Day / Week |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Arm Pain Rt or left | <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Stress | <input type="checkbox"/> Short Breath |
| <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Loss / Poor Sleep | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Leg pain Rt. or left | <input type="checkbox"/> Fever | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Hip Pain Rt. or left | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ear Ache or Ringing |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Other | <input type="checkbox"/> Menstrual Issues |

Referred To This Office By: _____

Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Care # _____

Have you tested HIV positive? yes no

I hereby authorize Alternative Health Clinic to examine me, including X-rays if indicated by the exam, and to release my records to anyone I designate in writing. I further authorize treatments deemed necessary by the findings and I request all my chiropractic records be held in strict confidence and not be given to anyone without my written consent. **I CLEARLY UNDERSTAND THAT I AM TOTALLY RESPONSIBLE FOR ALL CHARGES SHOULD MY INSURANCE COMPANY DENY PAYMENT.**

By signing your name below you certify the accuracy of your medical and/or accident history and further certify that you present to Alternative Health Clinic for evaluation and/or treatment of a health condition and for no other purpose.

Patient Signature: _____ Date: _____

Authorization to treat minor _____
(Parent or Guardian)