Motor Vehicle Accident
Chiropractic Intake Form

Name: _____ DOB _____ Date: _____

Insurance Information:
Name of Insurance Company: _____

Claims #: _____ Adjusters Name: _____

Phone # to reach Adjuster: _____ Claim open for Medical Billing: YES NO

Claims Filing Address: _____

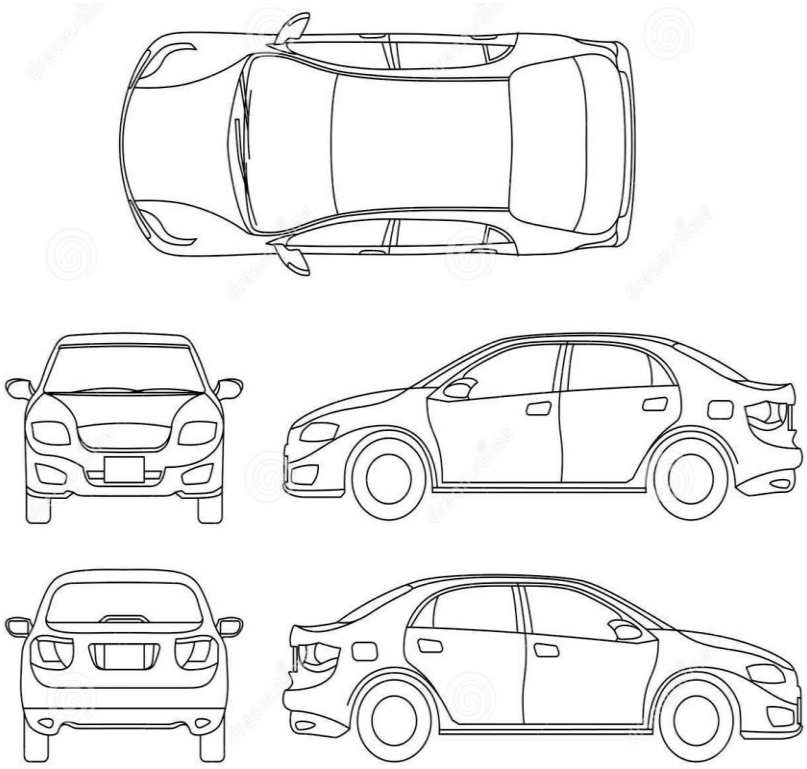
Other Party Insurance Company (If Applicable):
Name of Insurance Company: _____ Ins Phone #: _____

Secondary Claim #: _____

At Fault Party's Name: _____ Phone #: _____

ACCIDENT HISTORY:

Date of Accident: _____ Time of Accident: _____ AM or PM



State how the accident happened in your own words:

_____

_____

_____

_____

_____

_____

_____

← **Please indicate where your car was damaged to the best of your ability.**

Patient Signature: _____ Date: _____

ACCIDENT HISTORY:

Type of Vehicle: _____Year of Vehicle: _____

Were you driving the car? YES NO If NO, who was? _____

Did your vehicle strike anything else? (Tree, another car, side railing, etc.)_____

What were the weather conditions like? _____

How fast were you driving? _____

Were you driving distracted? _____

Were you wearing a seatbelt? YES NO

Did the Air Bags go off? YES NO

Did Police arrive at the accident? YES NO

Did EMS arrive at the accident? YES NO

What was the extent of damage done to your car? _____

What was the other type of vehicle involved in the accident? _____ Year_____

What was the extent of damage done to the other car? (If known) _____

INJURY HISTORY:

Did you hit any part of your body during the collision? (Head hit dashboard, chest hit steering wheel, etc.)

_____

Where are you feeling the pain now?

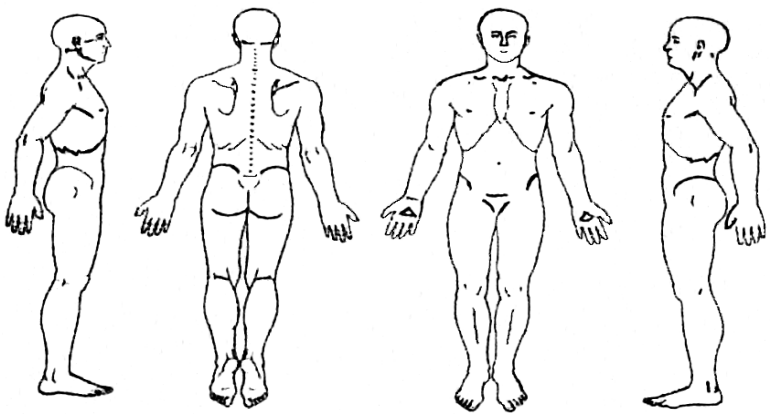
Condition #1 Main complaint: _____

Condition #2: Second complaint: _____

Condition #3: Third complaint: _____

Condition #4: Fourth complaint: _____

Please mark the image where you are feeling pain or discomfort. →



OFFICE USE ONLY
Height:
Weight:
Blood Pressure:
Pulse:

Patient Signature: _____ Date: _____

Please Rate the Pain of the complaints in the order listed above from 0-10:

(0= No pain) (10= Very Severe Pain)

Condition #1	0	1	2	3	4	5	6	7	8	9	10
Condition #2	0	1	2	3	4	5	6	7	8	9	10
Condition #3	0	1	2	3	4	5	6	7	8	9	10
Condition #4	0	1	2	3	4	5	6	7	8	9	10

Please Rate the Frequency at which you experience the pain throughout the day 0-100%:

(0-25%= zero-occasionally) (100%= Constant)

Condition #1	0%	25%	50%	75%	100%
Condition #2	0%	25%	50%	75%	100%
Condition #3	0%	25%	50%	75%	100%
Condition #4	0%	25%	50%	75%	100%

Please Describe the Pain:

Condition #1	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling
Condition #2	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling
Condition #3	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling
Condition #4	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling

When do you feel symptoms are worse? Morning Afternoon Night **Other:** _____

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

Has there been any new symptoms? _____

Did you lose consciousness during the accident? _____

Were you taken to the hospital after the accident? _____

Has your primary care doctor or any other doctor checked you out after the accident? _____

Name of Doctor: _____

Are you still under care? YES NO

Did you receive any treatments after the accident to help with the conditions you are presenting with today?

_____

What are your main physical limitations during the day? (Walking, stairs, sleeping, etc): _____

_____

Blue Ribbon Chiropractic
Keeping you and your champions in the winner's circle

Insurance Assignment, Release of Information, and Payment Agreement

Patient Name: _____

Assignment of Insurance Benefits:

I authorize and direct that payment be made directly to:

Lisa N. Braden, D.C., M.S.A.C.N., C.A.C.
Blue Ribbon Chiropractic LLC
101 East Park Avenue
Columbiana, Ohio 44408-1352

For any and all insurance benefits or reimbursement for services rendered by her which would otherwise be payable to me under any insurance or prepaid health care plan.

Date Patient Signature

Release of Information: I authorize the release of any information concerning my health and healthcare services to my insurance companies, pre-paid health plan, attorney and/or Medicare/Medicaid.

Date Patient Signature

Payment Agreement: I understand there is no guarantee that my insurance company(ies) or prepaid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand I am responsible for all remaining charges.

Date Patient Signature

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident.

For each one, please circle the number closest to your answer.

0= Not experienced at all
1= No more of a problem
2= A mild problem
3= A moderate problem
4= A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity/easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity/easily upset by bright light	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1._____	0	1	2	3	4
2._____	0	1	2	3	4

Patient signature:_____ Date:_____

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242:587-592

Functional Rating Index

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

For each one, circle the number closest to your answer.

0= Not experienced at all
1= No more of a problem
2= A mild problem
3= A moderate problem
4= A severe problem

1. Pain Intensity							
	No Pain	0	1	2	3	4	Worst pain possible
2. Sleeping							
	Perfect Sleep	0	1	2	3	4	Totally disturbed sleep
3. Personal Care (washing, dressing, etc.)							
	No pain/ restrictions	0	1	2	3	4	Severe pain; need assistance
4. Traveling (driving, etc.)							
	No pain	0	1	2	3	4	Severe pain on trips
5. Work							
	Can do work; No restrictions	0	1	2	3	4	Cannot work
6. Recreation							
	Can do all activities	0	1	2	3	4	Cannot do any activity
7. Frequency of Pain							
	No pain	0	1	2	3	4	Constant pain all day
8. Lifting							
	No pain	0	1	2	3	4	Increased pain with any weight
9. Walking							
	No pain; any Distance	0	1	2	3	4	Increased pain with all walking
10. Standing							
	No pain after Several hours	0	1	2	3	4	Increased pain with any standing

Patient Signature:_____ Date:_____