AUTO ACCIDENT FORM

FIT FOR LIFE CHIROPRACTIC CENTER
74 HORSENECK ROAD
MONTVILLE, NJ 07045

Patient Name:_____**Sex**: ☐ M ☐F **Date**: _____

Address:_____**City**:_____**State**:_____**Zip**:_____

Home Phone: ( )_____**Cell Phone** ( )_____**Age**:_____

Date of Birth:___/___/_____**Employer**:_____**Email**:_____

Personal Status: ☐ Single ☐ Married ☐ Divorced **Occupation:**_____

What is our preferred method of contact? ☐ Home Phone ☐ Cell Phone ☐ Email

Have you ever seen a chiropractor before? ☐Yes ☐No If yes, how long ago? _____

Smoking Status ☐Smokes every day ☐Smokes some days ☐Former Smoker ☐Never Smoked

Whom may we thank for your referral? _____

Insured Name:_____**Insurance Company:** _____

Insurance company address: _____

Claim Adjuster:_____**Phone Number**:_**ext**:_____

Policy number:_____**Claim number**: _____

Vitals:

Weight: _____ **Blood Pressure**:_____/_____

Height: _____

Have you ever been diagnosed with: Asthma? ☐Yes ☐ No

Diabetes? ☐Yes ☐No If yes, type? ☐1 ☐

2 High Blood Pressure? ☐Yes ☐No

1. **What was the date and time of the accident?** _____
2. **Was a police report written up for the accident? ☐ Yes ☐ No**
3. **How many vehicles were involved in the accident?** _____
4. **Where did the accident occur? (Please specify street or intersection, city, and state)** _____
   _____
5. **Was your vehicle struck by another vehicle?** ☐ Yes ☐ No

   Angles of Impact: First Collision: ☐ Right ☐Left ☐ Front ☐ Back

   Second Collision: ☐ Right ☐Left ☐ Front ☐ Back
6. **Did your vehicle hit anything after the accident?** ☐ Yes ☐ No

   If yes, please describe: _____

7. **What was your position in the car?** ☐ Driver ☐ Passenger

   If passenger, where were you sitting? ☐Right Rear ☐Center Rear ☐Left Rear ☐Front

8. **What type of vehicle were you in?** _____

9. **What type of vehicle impacted yours?** _____

10. **Describe what happened in your own words:** _____

    _____

    _____

    _____

11. **Were you wearing a seatbelt?** ☐ Yes ☐ No

12. **Did you brace for impact?** ☐ Yes ☐No If yes, I braced ☐ With my hands ☐ With my feet

13. **Which way were you facing at the time of the impact?** ☐ Right ☐ Left ☐Straight Ahead

14. **How fast were you moving at the time of the impact?**

    _____

15. **How fast was the other vehicle moving at the time of the impact?**

    _____

16. **Did your vehicle hit anything after the accident?** ☐ Yes ☐No

    If yes, please describe: _____

17. **Did you strike any part of your body at the time of the impact?** Yes No If

    yes, please specify what body part, and where it struck:

    ☐Steering Wheel _____ ☐Dashboard_____

    ☐Windshield _____ ☐ Roof _____

    ☐ Left Side Door _____ ☐ Right Side Door _____

    ☐ Other _____

18. **Immediately after the accident, how did you feel?**

    ☐Dizzy/ Dazed ☐Disoriented ☐Unconscious

    ☐Nervous ☐Nauseous ☐Upset

    ☐Weak ☐Other _____

19. **During and after the crash, what happened to your vehicle?**

    ☐Kept going straight ☐ Spun around

    ☐Kept going straight hitting a car in front ☐Spun around and hit a stationary object

    ☐Was hit by another vehicle ☐Hit a stationary object

20. **Did you lose consciousness during the accident?** ☐Yes ☐No

    If yes, please describe:_____

21. **Did your head hit anything during the accident?** ☐Yes ☐No

    If yes, please describe:_____

22. **Did your face hit anything during the accident?** ☐Yes ☐No

    If yes, please describe:_____

23. **Did your shoulders hit anything during the accident**? ☐Yes ☐No

    If yes, please describe: _____

24. **Did your neck hit anything during the accident?** ☐Yes ☐No

    If yes, please describe:_____

25. **Did your chest hit anything during the accident?** ☐Yes ☐No

    If yes, please describe:_____

26. **Did your hips hit anything during the accident?** ☐Yes ☐No

    If yes, please describe:_____

27. **Did your knees hit anything during the accident**? ☐Yes ☐No
    If yes, please describe:_____

28. **Did your feet hit anything during the accident?** ☐Yes ☐No
    If yes, please describe:_____

29. **Did you slide out of your seatbelt during the accident?** ☐Yes ☐No

30. **What was damaged on your vehicle?** (Check all that apply)

☐Windshield	☐Rear Bumper	☐Mirror
☐Steering Wheel	☐Front Bumper	☐Knee Bolster
☐Dashboard	☐Trunk	☐Back Right Door
☐Seat Frame	☐Front Left Door	☐Completely Totaled
☐Side Window	☐Front Right Door	
☐Rear Window	☐Back Left Door	

31. **Did you go to the hospital?** ☐Yes ☐No

    If yes: For how long? _____

    When did you go? ☐At the time of the accident ☐The next day

    How did you get there? ☐Ambulance ☐Police Car ☐Private transportation

    Name of the hospital: _____

    Attended by Dr: _____

32. **What treatment was given?** (Check all that apply)

☐None	☐Placed in cervical collar
☐X-Ray	☐Given Stitches
☐Bandaged	☐Given instructions regarding concussions
☐Given instructions regarding sprains/strains	☐Physical therapy
☐Instructed to call an orthopedic surgeon	☐Instructed to call private physician
☐Referred to this office for treatment	☐Given Medication
☐Other	

If given medication or other, please specify:_____

_____

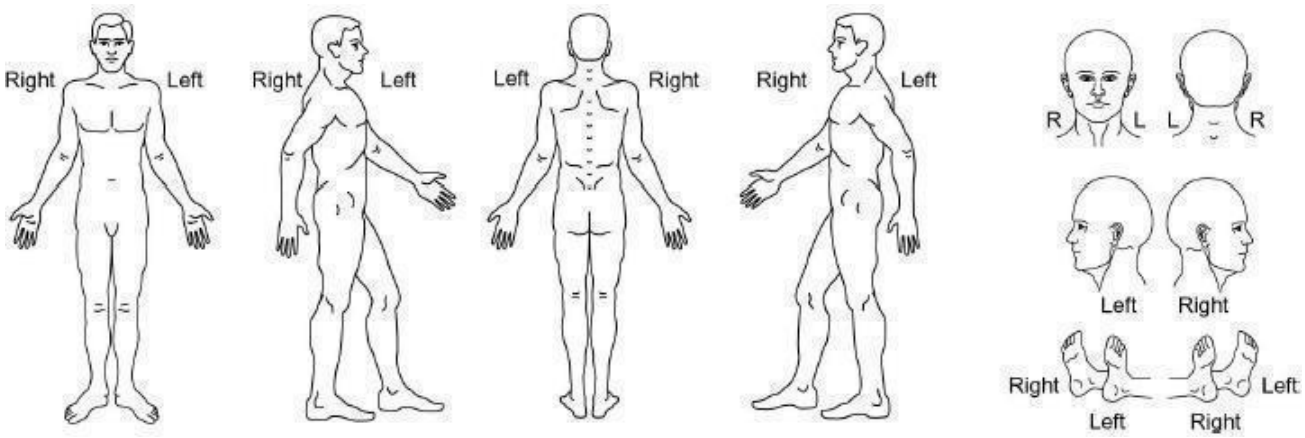
33. If you were x-rayed at the hospital, check where on your body:

☐Neck ☐Mid Back ☐Lower back ☐Other: _____

34. **Have you seen any other doctors as a result of this accident?** ☐Yes ☐No

If yes, whom? _____

35. Indicate on the drawings below where you have pain/symptoms:



36. How often do you experience symptoms?

☐Constantly (76%-100% of the time) ☐Frequently (51-75% of the time)

☐Occasionally (26-50%of the time) ☐Intermittently (1-25% of the time)

37. Please describe the type of pain:

☐Sharp ☐Numb

☐Dull ☐Tingly

☐Diffuse ☐Sharp with motion

☐Achy ☐Shooting with motion

☐Burning ☐Stabbing with motion

☐Shooting ☐Electric like with motion

☐Stiff ☐Other:

_____

38. How are your symptoms changing with time?

☐Getting worse ☐Staying the same ☐Getting better

39. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10

40. How much has the problem interfered with work and social activities?

☐Not at all ☐ A little bit ☐ Moderately ☐Quite a bit ☐Extremely

41. Do you consider this problem to be severe?

☐Yes ☐Yes, at times ☐No

42. What aggravates your problem?

_____

43. What alleviates the problem? _____

44. What concerns you most about your problem?

_____

_____

45. How would you rate your overall health?

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

46. What type of exercise do you do?

☐Strenuous ☐Moderate ☐Light ☐None

47. For each of the conditions below, please check in the "PAST" column is you have had the condition in the past. If you presently have a condition listed below, please place a check in the "PRESENT" column

PAST	PRESENT		PAST	PRESENT	
•	□	Headaches	•	□	High Blood Pressure
•	□	Neck Pain	•	□	Heart Attack
•	□	Upper Back Pain	•	□	Chest Pain
•	□	Mid Back Pain	•	□	Stroke
•	□	Low Back Pain	•	□	Angina
•	□	Shoulder Pain	•	□	Kidney Stones
•	□	Elbow/ Upper Arm Pain	•	□	Kidney Disorders
•	□	Wrist Pain	•	□	Bladder Infection
•	□	Hand Pain	•	□	Painful Urination
•	□	Hip Pain	•	□	Loss of Bladder Control
•	□	Upper Leg Pain	•	□	Prostate Problems
•	□	Knee Pain	•	□	Abnormal Weight Gain/Loss
•	□	Ankle/ Foot Pain	•	□	Loss of Appetite
•	□	Jaw Pain	•	□	Abnormal Pain
•	□	Joint Pain/ Stiffness	•	□	Ulcer
•	□	Arthritis	•	□	Hepatitis
•	□	Rheumatoid Arthritis	•	□	Liver/Gall Bladder Disorder
•	□	Cancer	•	□	General Fatigue
•	□	Tumor	•	□	Muscular Incoordination
•	□	Asthma	•	□	Visual Disturbances
•	□	Chronic Sinusitis	•	□	Dizziness
•	□	Other _____	•	□	Depression
•	□	Diabetes	•	□	Systemic Lupus
•	□	Excessive Thirst	•	□	Epilepsy
•	□	Frequent Urination	•	□	Dermatitis/ Eczema / Rash
•	□	Smoking/ Tobacco Use	•		FOR FEMALES ONLY:
•	□	Drug/ Alcohol Dependence	•	□	Birth Control Pills
•	□	Allergies	•	□	Hormonal replacement
			•	□	Pregnancy

48. Please indicate if any family members have had the following:

Rheumatoid Arthritis (☐Mother ☐Father) Diabetes (☐Mother ☐Father)

Lupus (☐Mother ☐Father) Heart problems (☐Mother ☐Father)

Cancer (☐Mother ☐Father) ALS (☐Mother ☐Father)

Other:_____(☐Mother ☐Father)

49. List all surgical procedures you have had:

_____

_____

_____

50. **Have you ever been hospitalized (Other than the above surgeries and accident?** ☐ Yes ☐No

If yes, why?_____

51. Please list all Prescription Medications you are currently taking:

Check here if not taking any medications: ☐

Name of Medication: i.e: Lipitor	**Strength and MD's instruction** i.e: 10mg, 2x daily	**Prescribing Physician**

52. Are you allergic to any medications? Please list each drug on a new line:

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. Penicillin	**Symptom if Taken:** i.e: Headache

53. Have you had previous injuries or accidents? _____

54. Description of previous accident: _____

55. Description of previous injuries: _____

56. How much better did you feel prior to your current condition? (1-100%) _____

PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FIT FOR LIFE CHIROPRACTIC CENTER IS PERMITTED BY LAW TO USE MY PERSONAL HEALTH INFORMTION TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FIT FOR LIFE CHIROPRACTIC CENTER HAS AGREED TO ASSIST ME IN BILLING MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES. ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE FOR ALL FEES I INCUR IN CONNECTION WITH SERVICES RENDERED FOR THE PURPOSE OF TODAY'S VISIT, AS WELL AS ANY FUTURE SERVICES FOR ANY CONDITION KNOWN OR AS OF YET UNKNOWN.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FIT FOR LIFE CHIROPRACTIC CENTER TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATES STATUES.

Patient Signature_____Date: _____

Coordination of Benefits Statement

I assign directly to Dr. Fano/Fit for Life Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

_____ _____

Print Name Signature

Do you have a Secondary Insurance? (circle one) **YES** **NO**

Name of Secondary Insurance Company _____

Name of Policy Holder_____Policy ID# _____

_____ _____

Print Name Signature

Hippa Form

We are required by State and Federal Law to maintain the privacy of your patient file and protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the rights to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you, in writing, as soon as possible, following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. David M Fano Privacy Officer

If you would like further information about our privacy policies and practices, please contact:

Dr. David M Fano Privacy Officer

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

Personal Representative (please print) Personal Representative Signature Date

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient's Signature Date

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- ❑ There is a possibility that I may be pregnant at this time.
- ❑ Yes. I am definitely pregnant
- ❑ No. I am definitely not pregnant at this time
- ❑ I request that x-ray films not be taken because _____

_____

Date of last menstrual period: _____

AUTHORIZATION FOR TAKING X-RAY FILMS

I understand and agree that this service rendered to me is charged directly to me and I'm responsible for payment of any unpaid balance directly to the Doctor. I further agree that the above named Doctor will keep the X-Rays at this office. X-Rays will be released upon proper authorization and consent signed by me, the patient. I consent to having X-rays taken at the above office by the above Doctor.

_____

Patient's Signature Date

Lower Back

Name:_____ **Date:**_____ **File#:**_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting
- ☐ I can lift heave weights without extra pain.
- ☐ I can life heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned. (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – Sitting
- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately

SECTION 6 – Standing
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it causes pain immediately.

SECTION 7 – Sleeping
- ☐ I get no pain in bed
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing...
- ☐ Pain has restricted my social life and I do not go out much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain

SECTION 9 - Traveling
- ☐ I get no pain while traveling
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does now compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except when done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 – Changing Degrees of Pain
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates, but overall is definitively getting better.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain gradually worsening.
- ☐ My pain is rapidly worsening

Patient Signature: _____

Neck Disability Index

Name:_____ **Date:**_____ **File#:**_____

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE ONE BOX THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY SECTION RELATE TO YOU, PLEASE MARK THE MOX THAT MOST CLOSELY DESCRIBES YOUR PRESENT DAY SITUATION.

SECTION 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of my self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – Lifting
- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if items are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK
- ☐ I can so as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – Concentration
- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – Driving
- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive because of severe neck pain.
- ☐ I can't drive my car at all because of neck pain.

SECTION 9 – Reading
- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all

SECTION 10 – Recreation
- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have some neck pain with most recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I can hardly so recreational activities sue to neck pain.
- ☐ I can't do any recreational activities due to neck pain

Patient Signature: _____

Score:_____[50] % Score= _____

INFORMED CONSENT TO TREAT

Please read this entire section prior to signing. It is important that you understand the information contained in this section. If anything is unclear, please ask questions before you sign.

DO NOT SIGN THIS CONSENT TO BE TREATED UNTIL YOU HAVE READ, UNDERSTAND AND ASKED ANY QUESTIONS THAT YOU MAY HAVE!

Chiropractic Manipulation and Therapy Risks:

As with any healthcare procedure, there are certain complications which may arise during or after chiropractic manipulation of the spine and/or extremities and with the use of physical therapy treatments. These complications include but are not limited to: fractures of bones, spinal disc injuries, joint dislocations, muscle injuries, nerve injury, worsening symptoms and rib injuries. These complications are generally described as rare.

Manipulation of the neck has been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million or more neck adjustments.

Having been informed of these risk factors, I hereby attest that I understand the terms used in the above paragraphs and give my consent for chiropractic treatment.

_____ _____

Patient/Guardian Name Printed Date

_____ _____

Patient/Guardian Signature Relationship to Patient

I have addressed any questions regarding consent to treat:

_____

Doctor Signature