

# Motor Vehicle Accident Information

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  Mr.  Miss  Mrs.  Ms. Marital status (circle one)  
Single / Mar / Div / Sep /  
Widow

Street address: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Social Security no.: \_\_\_\_\_ Home phone: \_\_\_\_\_  
P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

## General Information

**Location** (circle one) **Driver** **Passenger** Location (circle one) Front / Middle / Rear  
Position (circle one) Left / Middle / Right

## Work from Left to Right and Circle One

**Type :** Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:  
**Size :** Mini / Sub Comp / compact / Mid Size / Full Size  
**Action :** Stopped / Slowing / Acceleration / Cruising  
**Speed :** (MPH)  
**Time of Accident:** Day Light / Dawn / Dusk / Dark  
**Road Condition :** Dry / Damp / Wet / Snow / Ice  
**Visibility :** Good / Fair / Poor

Enter impact information for up to three Vehicles or Objects

### Impact Information: Vehicle or Object (I)

(Select one) **Name Object :**  
 **Vehicle** **Vehicle Type :** Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:  
**Size :** Mini / Sub Comp / compact / Mid Size / Full Size  
 **Object** **Damage to Veh.:** Minimal / Moderate / Extensive / Totaled / Unsure

**Impact  
Location**

### Impact Information: Vehicle or Object (II)

(Select one) **Name Object :**  
 **Vehicle** **Vehicle Type :** Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:  
**Size :** Mini / Sub Comp / compact / Mid Size / Full Size  
 **Object** **Damage to Veh.:** Minimal / Moderate / Extensive / Totaled / Unsure

**Impact  
Location**

**Impact Information: Vehicle or Object (III)**

(Select one)

**Name Object :**

- Vehicle**      **Vehicle Type :** Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
- Object**      **Size :** Mini / Sub Comp / compact / Mid Size / Full Size
- Damage to Veh.:** Minimal / Moderate / Extensive / Totaled / Unsure

**Impact Location**

**During Impact Information:**

- Seat Belt?       Yes       No      Brakes Applied ?       Yes       No
- Air Bag Deployed?       Yes       No      Seat Broken ?       Yes       No
- Seat Back position Changed?       Yes       No

Head Rest : (Circle one)      Low / Mid / High / None

Prepare for Accident: (Circle One)      Un-expected / Expected / Expected and Braced

Body Position : (Circle one)      Straight / Rotated Left / Rotated Right / Unsure / Other:

Body Thrown?       Yes /  No

Direction of Throw :(Circle One)      Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :      Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:

Head Motion :      Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

**Body Impact**

- Head       Upper Back       Right hand       Lower Back
- Left Shoulder       Left Leg       Mid Torso       Right Foot
- Left Arm       Right Leg       Mid Back       Left Foot
- Left Elbow       Right Shoulder       Right Knee       Other :
- Left hand       Right Arm       Left Knee
- Upper Front Torso       Right Elbow       Lower Front Torso

**After Accident Information:**

- Dizzy/dazed     Upset     Weak     Nervous     Headache     Disoriented     Unconscious

Immediately After Accident:      /Other:

**Pain**

- Head       Left foot       Right foot       Left Knee
- Left Hand       Left Shoulder       Right Shoulder       Right knee
- Right Arm       Left Elbow       Left Arm       Other :
- Upper Front Torso       Mid Torso       Right elbow
- Upper Back       Mid back       Lower Front Torso
- Left Leg       Right Leg       Lower Back

Numbness:

- Left Hand     Right Hand     Left Leg     Right Leg     Left Upper Arm

Right Upper Arm  Left Foot  Right Foot  Other:

### Medicare Information

Medical Care?  Yes  No

Time of care Next day / At time of Accident / Later that Day / Days Later: (Specify)

Transported Drove Self / Ambulance / Other

Went To Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)

Admitted to Hospital?  Yes  No Days Spent in Hospita:

Test:  X-ray  Lab Work  MRI  CT Scan  Other:(Specify)

Treatment:  Ice Pack  Hot Pack  None  Cervical Collar  Medication  Other:(Specify)

### Previous Injuries

Yes  No

Specify:

Previous Injuries / Accidents

Yes  No

Residual pain from Previous Injuries/Accidents Specify:

### Later Symptoms

Head  Headache  Dizziness  Blurred Vision  Light Headedness  Loss of Vision  
 Fainting  Loss of Memory  Pain in ear  Double Vision  
 Other Specify: \_\_\_\_\_

Neck (with Movement)  Pain in Neck  Forward  Backward  Turn Left  Popping in Neck  
 Muscle Spasms  Turn Right  Bend Left  bend Right

Shoulders  Other Specify: \_\_\_\_\_  
 Pain in Shoulder joint  Tension in shoulders  Muscle Spasms in Shoulder  
 Pain across shoulder  Cant raise arms above [ ] Above shoulder level [ ] Over head

Arms and Hands  Other Specify: \_\_\_\_\_  
 Pain in Fingers  Numbness in Left Arm  Hands Cold  
 Pin & needles in hands  Numbness in Right Arm  Loss of Grip Strength  
 Pin & needles in fingers  Swollen joints in Fingers

Chest  Other Specify: \_\_\_\_\_  
 Chest pain  Pain Around Ribs  Shortness of Breadth  Breast Pain

Abdomen  Other Specify: \_\_\_\_\_  
 Nervous Stomach  Nausea  Diarrhea  Gas  Constipation

Mid back  Other Specify: \_\_\_\_\_  
 Sharp Stabbing  Mid pain back  Pain From front to back  Dull Ache  
 Pain in Kidney Area  Muscle Spasms  Pain between shoulders

**Later Symptoms Contd:**

Low Back Pain

Low back pain is worse when

Lower Back

- Working     Lifting     Stooping     Standing  
 Sitting     Bending     Coughing     Lying Down     Muscle Spasms

Other Specify: \_\_\_\_\_

Hips, Legs & Feet

- Pain in Buttocks     Pain and needles in Legs     Pain down leg  
 Pain in hip joint     Feet feel Cold     Swollen Feet  
 Numbness in Toes     Numbness of Leg     Knee pain  
 Leg cramps     Cramps in Feet

Other Specify: \_\_\_\_\_

- Nervousness     Fatigue  
 Irritable     Depressed  
 Generally Feel Rundown     Prostrate Pain/Swelling  
 Difficulty Urinating     Night Urination  
 Cramping     Irregularity

Loss of Sleep : [ \_\_\_\_\_ ] hrs

Loss of weight : [ \_\_\_\_\_ ] lbs

General

Gain weight : [ \_\_\_\_\_ ] lbs

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## OSWESTRY INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back 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 one section relate to you, please mark the box that **most closely** describes your present -day situation.

### SECTION 1 - PAIN INTENSITY

- My pain is mild to moderate. I do not need pain killers.
- The pain is bad, but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain.

### 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 manage most of my personal care.
- I need help every day in most aspects of 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 can manage if items are conveniently positioned, ie. 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 - WALKING

- I can walk as far as I wish.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can walk only if I use a cane or crutches.
- I am in bed or in a chair for most of every day.

### SECTION 5 - SITTING

- I can sit in any chair for as long as I like.
- I can sit in my favorite chair only, but for as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### SECTION 6 - STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

### SECTION 7 - SLEEPING

- Pain does not prevent me from sleeping well.
- I sleep well but only when taking medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

### SECTION 8 - SOCIAL LIFE

- Social life is normal and causes me no extra pain.
- Social life is normal, but increases the degree of pain.
- Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- Pain has restricted my social life, and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

### SECTION 9 - SEXUAL ACTIVITY

- Sexual activity is normal and causes no extra pain.
- Sexual activity is normal, but causes some extra pain.
- Sexual activity is nearly normal, but is very painful.
- Sexual activity is severely restricted by pain.
- Sexual activity is nearly absent because of pain.
- Pain prevents any sexual activity at all.

### SECTION 10 - TRAVELING

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to necessary journeys under 1/2 hr.
- Pain prevents traveling except to the doctor/hospital.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

SCORE \_\_\_\_\_ [50]

BENCHMARK -5 = \_\_\_\_\_



**NOTICE OF DOCTOR'S LIEN**

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_

Date of Accident \_\_\_\_\_

Claim or File Number \_\_\_\_\_

Policy Number \_\_\_\_\_

I do hereby authorize Back2Health to furnish you, my attorney, with a full report of his examination, and diagnosis, in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said clinic such sums as may be due and owing him for chiropractic services rendered to me both by reason of the any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said clinic. And I hereby further give a lien on my case to said clinic against any and all proceeds of settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said clinic for all chiropractic bills submitted by the clinic for service rendered to me and that this agreement is made solely for the clinic's additional protection and in consideration of her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree promptly notify said doctor of any change or addition of attorney used by me in connection with this accident, and I instruct my attorney to do the same to promptly deliver a copy of the lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and cost.

Dated: \_\_\_\_\_

Attorney: \_\_\_\_\_

Please date, sign, and return one copy to doctor's office by \_\_\_\_\_.  
Also, keep one copy for your records.

Sincerely,



**CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS**

**DATE:** \_\_\_\_\_

Back2health Chiropractic has informed me that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Back2health Chiropractic to perform such radiographic examination necessary to diagnose and administer whatever treatment is deemed necessary to treat my present condition.

\_\_\_\_\_  
**Patient's signature**

\_\_\_\_\_  
**Witness signature**

**FOR OUR FEMALE PATIENTS**

To the best of my knowledge, I am not pregnant and the above mentioned doctor has my permission to x-ray me for a diagnostic interpretation.

\_\_\_\_\_  
**Patient's signature**

**BACK 2 HEALTH CHIROPRACTIC  
FINANCIAL POLICY**

**AUTO ACCIDENT / PERSONAL INJURY**

Patients involved in personal injury accidents may receive 100% coverage for their medical treatment under the Personal Injury Protection (PIP) of their auto insurance policy up to the policy limits.

**OFFICE POLICY**

**\*\*1. You are required to provide our office with the following insurance information by your second visit: the name of your auto insurance carrier, their address, phone number, as well as the claim and policy numbers.**

**\*\*2. If you have an attorney, you will need to provide us with their information by your second visit. You and your attorney will be required to sign an attorney's lien.**

**\*\*3. Regardless of who is at fault for the accident, a claim will be established with the insurance carrier for the car in which you were seated or your auto insurance carrier if either policy contained PIP/MedPay benefits. This office may submit any bills to the involved insurance carrier and/or attorney. If your bill for treatment is not paid in full by the auto insurance carrier, we may bill your health insurance carrier for any outstanding charges.**

**\*\*4. You are personally responsible for your bill. However, we may choose not to require payment at the time of service, as long as we are billing the correct insurance carrier and/or attorney and receiving payment.**

**\*\*5. If you or your attorney receives an insurance payment for services rendered by our office, that payment is due in our office within 10 business days. Your attorney, as well as yourself will not be permitted to make "payments" on an insurance check mailed to you. In addition, if you have a remaining balance due on your account when your case settles, you have 10 business days to render payment of that balance.**

**\*\*6. If any insurance claim or personal information changes during the course of treatment, you are required to inform this office immediately. (Such as insurance policy/plan updates or terminates, you have moved, or changed your phone number, etc.)**

**\*\*7. If you receive a bill, the payment is due upon receipt. All accounts with a balance over 45 days will be assessed a 1% late charge per month on the unpaid monthly balance. Payment plans can be arranged through the Billing department (410-517-2400). In the event that an account becomes assigned to a collection agency, the patient will pay 100% of collection agency fees, 100% of court costs, and 100% of attorney's fees.**

**\*\*8. There are a certain number of appointments available each day and often patients who are in pain are unable to be scheduled the same day that they call. With this in mind, if you are unable to keep a scheduled appointment, we ask that you give us the courtesy of a phone call, so that we may schedule another patient in that time slot. Thank you for your cooperation.**

**\*\*\*\* I HAVE READ, UNDERSTAND, AND ACCEPT THESE POLICIES IN FULL.**

**PATIENT SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_**

*Back<sup>2</sup>Health*  
*Chiropractic*



CLAIM NUMBER \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

\_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_

**To Whom It My Concern:**

**I have made a written agreement with Back2Health, LLC, that the services (medical pay) check due from your company upon settlement will be made payable directly to them on my behalf.**

**Sincerely,**

\_\_\_\_\_  
**Patient Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Witness' Signature**