SKAMANIA CHIROPRACTIC & REHABILITATION
27 Russell Ave, Lower Suite / P.O. Box 1498 / Stevenson, WA 98648
P: 509-427-3600 / F: 509-427-3601

Injury Intake

Please note that all information is strictly confidential.

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If I believe that I cannot assist you with your health care needs, I will be more than happy to refer you to the appropriate health care professional. If you have any questions, please ask. Thank you.

First Name: Middle Initial:

Last Name:

Date of Birth: / / Age:

Gender: [ ] Male [ ] Female Height: Weight:

Marital Status: [ ] Married [ ] Single [ ] Life Partner

Address: **City/State/Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Email:

As a courtesy, we utilize EMAIL or TEXT MESSAGE for appointment reminders for our patients. Please choose ONE.

☐ **Text message (phone number):** ____________________

☐ **E-mail address**: ____________________

Occupation: **Employer:**

In Case of Emergency Contact: Relationship & Phone:

Primary Care Provider: **Phone:**

INSURANCE COMPANY INFORMATION

Insurance Company: Claim #:

Address:

Adjuster Name: Phone:

OTHER DRIVER'S INSURANCE INFORMATION

Insurance Company: Claim #:

Address:

Adjuster Name: Phone:

Patient/Guardian Signature: ____________________ **Date:** ____________

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Date of accident: _____/_____/_____ Time of accident: am/pm

Location of accident (street/highway) in (city)

As a □ driver □ passenger □ pedestrian □ bicyclist Was anyone else in the car with you?

Drivers License #

Type of accident: Auto / Slip or Fall / Work related

Incident Report Taken: □ Yes □ No If yes, we will need a complete copy of the report

Police Report Taken: □ Yes □ No If yes, we will need a complete copy of the report

Have you retained the services of an attorney? □ Yes □ No

If yes, Attorney's name: Phone:

Address: Fax:

Have you missed time from work? □ Yes □ No □ Have been unable to work since accident

If yes, please list the dates or time range you have missed:

Road Condition: ☐wet ☐dry ☐snow/ice ☐other_____________________________________

Collision involved: ☐one vehicle ☐2 vehicles ☐3 or more vehicles ☐pedestrian ☐other

Did you go to the hospital afterwards? ☐Y ☐N Hospital____________How did you get there? _______________

Were you examined by a doctor? ☐Y ☐N Were X-rays taken? ☐Y ☐N Body parts x-rayed________________

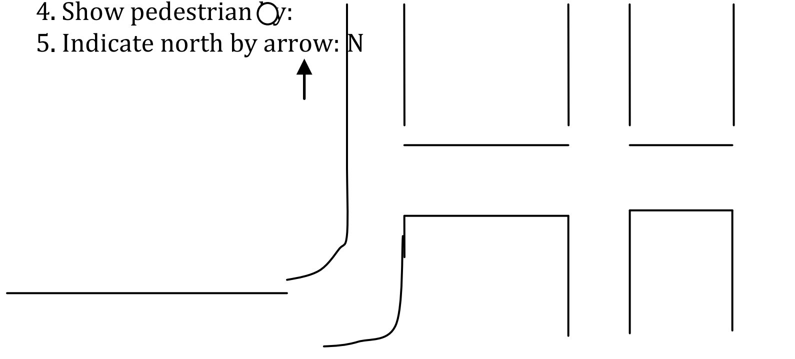
What did the doctor say was wrong? ____

Treatment given___________________________ Medications given_______________________________

INDICATE ON THIS DRAWING WHAT HAPPENED

SKETCH IN THE SCENE OF YOUR ACCIDENT, WRITING IN STREET OR HIGHWAY NAMES

1. Number vehicles (1 for yours) and show direction of travel by an arrow:
2. Use solid line to show path before accident and dotted line after - - - - - -
3. Show distance and direction to landmarks; identify landmarks by name/number.
4. Show pedestrian by:
5. Indicate north by arrow: N



1. Driver of car____________ Where were you seated? ☐Driver ☐Front passenger ☐Rear left ☐Rear right

2. Other occupants in car and their injuries____

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3. You were struck from: ☐Behind ☐ Front ☐ Left side ☐Right side ☐ Other

4. Were you aware of the collision prior to impact? ☐Y ☐N Did you brace for impact? ☐Y ☐N

5. How far is the headrest (or seatback) from your head? ☐ less than 3” ☐3 to 6” ☐more than 6”

6. Were you wearing a: ☐seatbelt ☐shoulder harness ☐none

7. Did the airbag deploy? ☐Y ☐N

8. Year/make/model of the car you were in___________ Est. cost of damage $_____Was it drivable? ☐Y☐ N

9. What car parts were damaged? (e.g. seatback, window, rearview mirror, etc.)_______________________

____

10. Was your car moving at the time of collision?☐Y ☐N If yes, how fast? ____Mph.

Were you braking? ☐Y☐ N If no, was the driver’s foot on the brake? ☐Y ☐N

11. Did your body or head strike anything in the car? ____

12. Was your head: ☐Pointed straight forward ☐Turned to the left ☐Turned to the right

13. Year/make/model of OTHER car damage: ☐ minor ☐ moderate ☐ severe Was it drivable? ☐Y ☐ N

14. Was the other car moving at the time of collision? ☐Y ☐N If yes, how fast? ___Mph.

15. If moving, was the other vehicle ☐ slowing down ☐ gaining speed ☐ traveling at a steady speed

16. Describe how the accident happened:____

____

SYPMTOMS FROM ACCIDENT

17. Describe where you felt pain or unusual feelings: (location, type, severity)
a) During the accident____

b) Immediately after the accident____

c) Later that day/night: (and up to now)____

18. Did you lose consciousness (black-out)?☐Y ☐N If yes, for how long? ___If no, were you dazed/confused?☐Y ☐N

19. Did you experience a flash of light or explosion in your head? ☐Y ☐N

20. Did you receive any injuries/bruises/cuts from the seatbelt or airbag? ☐Y ☐N

21. Did you receive bleeding cuts? ☐Y ☐N Did you receive bruises? ☐Y ☐N Where?____________________

22. Check the symptoms you have noticed since the accident:

☐Headache	☐Ringing/buzzing in ears	☐Sleeping problems	☐Diarrhea/constipation
☐Neck pain/stiffness	☐Loss of smell/taste	☐Numbness in toes	☐Stomach upset/pain
☐Mid back pain	☐Loss of memory	☐Numbness in fingers	☐Shortness of breath
☐Low back pain	☐Fatigue	☐Pins/needles in arms	☐Blood in urine
☐Jaw pain	☐Tension	☐Pins/needles in legs	☐Chest pain
☐Shoulder/arm/wrist pain	☐Difficulty concentrating	☐Cold hands/feet	☐Depression
☐Hip/leg/knee/ankle pain	☐Dizziness/loss of balance	☐Restlessness	☐Nervousness/anxiety
☐Eyes sensitive to light	☐Forgetfulness	☐Head feels too heavy	☐Other_______________

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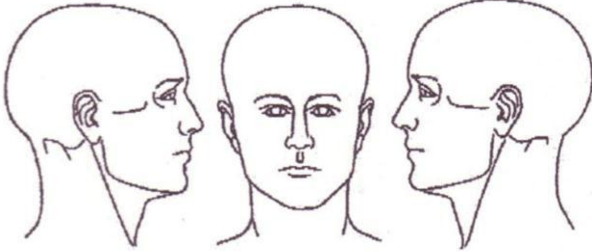
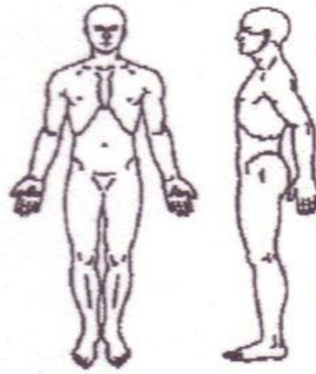
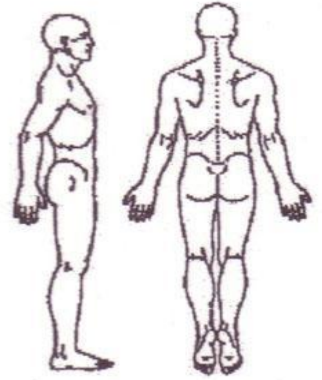
Please indicate any areas causing pain or distress:







23. Since this injury, are your symptoms? ☐Improving ☐Getting worse ☐Staying about the same

24. When are your symptoms worst? ☐Morning ☐ Afternoon ☐Evening ☐ Night

25. How did you feel before the accident?______________________________

26. Ongoing conditions/complaints experienced before accident______________________

27. Are your work activities restricted because of your injuries? ☐Y ☐N Last date worked__________

28. Have you lost time from work as a result of this accident? ☐Y ☐N Explain________________

29. Describe your work duties______________________________

30. Have you injured this area of your body before? ☐ Y ☐ N If yes, explain________________

31. If you have been in other auto or work accidents, list year and describe briefly:
    1)______________________________
    2)______________________________
    3)______________________________

32. Have you seen any other doctors as a result of this accident? ☐Y ☐N If yes, by whom?__________

33. What was the treatment (if any)?____________________Did it help? ☐Y ☐ N

34. Are you pregnant? ☐Y ☐N Date of last menstrual period__________

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ACTIVITIES OF DAILY LIVING

Do you notice any daily activities that are different now than from before the accident? ☐ Yes ☐ No

If yes, list them specifically: Activities you are UNABLE to do ____________

Activities that are PAINFUL to do ____________

Activities that are DIFFICULT to do ____________

PAIN INTENSITY

Please rate on a scale of 1-10 (1 being the least pain, 10 being the most pain)

☐ Neck Pain ________ ☐ Mid back Pain ________ ☐ Low back Pain ________ ☐ Other:________

☐ Sleeping ________ ☐ Personal care ________ ☐ Traveling ________ ☐ Work________

☐ Lifting ________ ☐ Walking ________ ☐ Standing________ ☐ Recreation ________

FREQUENCY OF PAIN

☐ No pain ☐ Occasional 25% ☐ Intermittent 50% ☐ Frequent 75% ☐ Constant 100%

PAST MEDICAL HISTORY

Please note dates of each:

☐ Mental Illness	☐ Diabetes	☐ Hepatitis	☐ HIV+	☐ AIDS	☐ Herpes
☐ High Blood Pressure	☐ Heart Disease	☐ Asthma	☐ Allergies	☐ Stroke	☐ Arthritis
☐ Chronic Fatigue	☐ Gall Stones	☐ Venereal Disease	☐ Osteoporosis	☐ Seizures	☐ Parasites
☐ Mononucleosis	☐ Rheumatic Fever	☐ Thyroid Problems	☐ Kidney Stones	☐ Ulcers	☐ Cancer

☐ Other ____________

Surgeries (types & dates): ____________

Significant Traumas: ____________

Significant Dental Work: ____________

Other: ____________

Allergies (drugs, chemicals, foods, etc.): ____________

Occupational Stress (chemical, physical, psychological): ____________

Birth History (prolonged labor, forceps, premature, etc.): ____________

FAMILY MEDICAL HISTORY

☐ Cancer	☐ Heart Disease	☐ Asthma	☐ Diabetes	☐ Stroke
☐ Allergies	☐ High Blood Pressure	☐ Seizures	☐ Other ____________	

What medications and/or supplements are you currently taking? ____________

____

Thank you for taking the time to fill out this form thoroughly.

Patient/Guardian Signature: ____________ **Date:** ____________

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CONSENT TO TREATMENT

To Skamania Chiropractic and Rehabilitation Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat or ice application, manual muscle therapy, and therapeutic exercises) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, skin irritations and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I give my permission and consent to the procedure or treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient/Guardian Signature______________________________ **Date**____________

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided for you.

Skamania Chiropractic & Rehabilitation, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Skamania Chiropractic & Rehabilitation, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Skamania Chiropractic & Rehabilitation, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Skamania Chiropractic & Rehabilitation, LLC may disclose your information for public health activities, to funeral directors in order to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restrictions, report and obtain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

Skamania Chiropractic & Rehabilitation, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative reasons other than those listed above and permitted under law.

Patient/Guardian Signature______________________________ **Date**____________

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FINANCIAL AGREEMENT

We are committed providing you with the best possible care. If you have medical insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve the goals, we need your assistance and your understanding of your payment policy.

Payment for services are due at the time of your visit unless payment arrangements have been made in advance. We accept cash, checks, Visa, MasterCard, Discover, and AMEX. We will be happy to process your insurance claim.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1% per month.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region.
3. Not all services are a covered benefit in all contracts. Some insurance companies' arbitrarily select certain services they will not cover.

We must emphasize that as chiropractic care provider, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Release of Benefits: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

Patient/Guardian Signature____ **Date**________________