Date_____ Home Phone_____ Cell Phone_____ Email_____
Patient Last Name_____ First Name_____ Initial_____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security #_____ Driver's License #_____
Insured Name_____ How and where did you learn about this clinic?_____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City_____ State_____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____ SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____ Phone_____ Occupation_____ City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>?** ☐ **Yes** ☐ **No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u>, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA</u>. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

8436 W. 3rd St., Suite 800, Los Angeles, CA 90048
2573-B Pacific Coast Highway, Torrance, CA 90505

Insurance Liability Waiver

Pursuant to insurance guidelines, I have been informed that **Daniel P. Loder, M.D. is out-of-network** with some insurance plans.

Although I have medical insurance coverage, the office visit and/or procedure I am going to receive may or may not be covered by my insurance policy and may be classified as "investigational and/or experimental" or may not be covered due to the medical practice being out-of-network. Depending on my insurance coverage, I may have a deductible, co-insurance, and/or out-of-pocket maximum that I will be liable to pay prior to my visit/procedure date.

Having been fully informed of this possibility, I have the right to accept these conditions and proceed with the procedure and/or office visit, or I have the option to decline treatment. If I am an out-of-network patient, I also understand that there may be an upfront payment that is required, such as copay.

I further understand that Daniel P. Loder, M.D. will bill my insurance carrier as a courtesy for amounts above my deductible, co-insurance, and out-of-pocket maximum. However, if these are not paid by my insurance carrier, I am liable for all services provided to me.

Please check one (1) of the following boxes:

☐ I understand and **accept these conditions** and have decided to **proceed** with the office visit and/or procedure.

☐ I understand but **do not accept these conditions** and have decided **not to proceed** with the office visit and/or procedure.

Patient Name _____ **Date of Birth** _____

Patient Signature _____ **Date** _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. Authorization

I authorize Daniel P. Loder, M.D. to use and disclose the protected health information described below to the

follow person(s) _____

(i.e. yourself, relative, referring physician, other physician - whomever you would like to access records of your care).

2. Effective Period

This authorization for release of information covers the period of healthcare from the below dates:

☐ all past, present, and future periods OR _____ to _____

3. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

☐ I authorize the release of my complete health record with the exception of the following:

- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effective until date listed in item (2) above, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed name of patient/guardian	Signature of patient/guardian	Date

DANIEL LODER, M.D.

8436 W. 3rd St., Suite 800, Los Angeles, CA 90048
2573-B Pacific Coast Highway, Torrance, CA 90505

Narcotic Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and our provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine---like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medication(s) and agree to take the medication(s) only as prescribed.
    a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
    b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal.
        i. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24i 48 hours after the last dose and can last up to 3 weeks.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Dr. Daniel Loder.
3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).
   It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.
4. I understand that the opioid medication is strictly for my own use. The opioid should **NEVER** be given or sold to others because it may endanger that person's health and is against the law.
5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.
6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by Dr. Daniel Loder. After I have been placed on a stable dose, I may receive opioids from my primary care physician and will return to our office for a medical evaluation at least once every six months.
7. I understand that opioid prescriptions will not be mailed. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.
8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement will result in termination of the doctor/patient relationship.
9. I will communicate fully with my physician to the best of my ability at the initial and all followi up visits my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust your treatment plan accordingly.
10. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.
11. The use of alcohol together with opioid medications is contraindicated.
12. Because I am responsible for my opioid prescription(s), I understand that:
    a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the same pharmacy.
    b. It is my responsibility to schedule appointments for the next opioid refill.
    c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. *If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.*
    d. Refills will NOT be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
    e. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.
    f. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.
    g. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
    h. If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments, once again, will not be granted.
    i. No "walki in" appointments for opioid refills will be granted.

13. While physical dependence is to be expected after longi term use of opioids, signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.
    a. Physical dependence is common to many drugs such as blood pressure medications, anti seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.
    b. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.
    c. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.
14. If it appears to Dr. Loder that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.
15. If I have a history of alcohol or drug misuse/addiction, I must notify Dr. Loder of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a necessity.
16. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra IF the prescription ends on a weekend or holiday. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.
17. I agree and understand that Dr. Loder reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a noni prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.
18. I agree to allow Dr. Loder to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it is necessary*.
19. I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary*.
20. I understand that noni compliance with the above conditions may result in a rei evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient Name **Date of Birth**

Patient Signature **Date**

8436 W. 3rd St., Suite 800, Los Angeles, CA 90048
2573-B Pacific Coast Highway, Torrance, CA 90505

PATIENT INFORMATION			
Last Name, First Name:		**Middle:**	**Marital Status:**
Date of Birth:	**Age:**	**Race/Ethnicity:**	**Preferred Language:**
Social Security Number:	**Sex:**	**Height:**	**Weight:**
Address:		**Home Phone:**	**Mobile:**
Email Address:		**Occupation:** ☐ Not currently working/disabled.	**Work Phone:**
Pharmacy Name and Phone Number:			

EMERGENCY CONTACT INFORMATION		
Name:	**Relationship to Patient:**	
Address:	**Home Phone:**	**Mobile:**

REFERRAL INFORMATION	
How were you referred to this office? ☐ SELF-REFERRED	**Primary Care Physician Name and Phone Number:**

INSURANCE INFORMATION	
Primary Insurance:	**Member ID:**
Provider Customer Service Phone Number:	**Group Number:**
Secondary Insurance:	**Member ID:**
Provider Customer Service Phone Number:	**Group Number:**
Is this a Workers' Compensation case? ☐ YES ☐ NO **If yes, please provide our office copy of authorization letter, adjuster contact info, claim number, and date of injury.*	**Do you currently have any legal action pending for this medical condition?** ☐ YES ☐ NO **If yes, please provide signed lien agreement and attorney information.*

Please complete this paperwork in its entirety. We rely on its completeness to provide you with the best possible care.

CHIEF COMPLAINT – *please be as detailed as possible!*

What brings you here today?

When did this problem start (date of injury)?

Have you experienced this problem previously? If yes, how long ago?

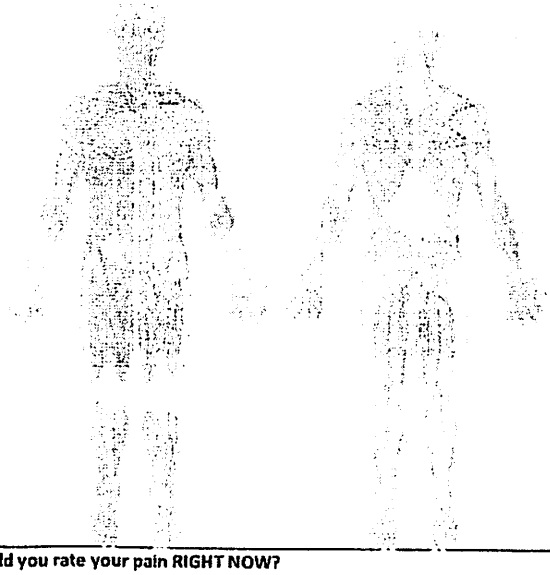
How do you think this problem began?

How often do you experience your symptoms and how long does the symptoms last?

When is your pain at its worst? Please check all that apply. ☐ morning ☐ daytime ☐ evening ☐ middle of the night ☐ always the same

Please draw the appropriate symbol(s) in the area of pain:

Burning	= = = = =
Cramping	□□□□□
Dull / Aching	0 0 0 0 0 0
Sharp / Stabbing	x x x x x x
Throbbing	Δ Δ Δ Δ Δ
Tingling / Pins / Needles	~ ~ ~ ~ ~



If "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate anywhere in your body? If yes, where?

Are you experiencing any weakness in your arms or legs? If yes, for how long?

Are you experiencing any bladder or bowel incontinence? If yes, for how long?

How are your symptoms changing with time? ☐ getting better ☐ not changing ☐ worse

Who else have you seen for this problem? Please check all that apply. ☐ Pain Management ☐ Spine Surgeon ☐ Orthopedist ☐ Physical Therapist ☐ Massage Therapist ☐ Neurologist ☐ Primary Care Physician ☐ Rheumatologist ☐ Other:

DANIEL LODER M.D.

PAIN LEVEL – *please mark how each action listed below affects your pain level.*					
Sitting	☐ increase	☐ decrease	Coughing/Sneezing	☐ increase	☐ decrease
Rising from sitting	☐ increase	☐ decrease	Household chores	☐ increase	☐ decrease
Standing	☐ increase	☐ decrease	Lifting objects	☐ increase	☐ decrease
Walking	☐ increase	☐ decrease	Reaching overhead	☐ increase	☐ decrease
Lying down	☐ increase	☐ decrease	Showering/Bathing	☐ increase	☐ decrease
Bending forward	☐ increase	☐ decrease	Looking side-to-side	☐ increase	☐ decrease
Bending backward	☐ increase	☐ decrease	Looking up	☐ increase	☐ decrease
Driving	☐ increase	☐ decrease	Looking down	☐ increase	☐ decrease
Twisting	☐ increase	☐ decrease	Changing positions	☐ increase	☐ decrease

Is there any activity not listed above that your pain keeps you from doing?

CONSERVATIVE TREATMENT – *please mark the treatments you have attempted and the effects.*			
Medication(s)	☐ helped	☐ worsened	☐ same / no effect
Physical Therapy	☐ helped	☐ worsened	☐ same / no effect
Chiropractic Treatment	☐ helped	☐ worsened	☐ same / no effect
Massage Therapy	☐ helped	☐ worsened	☐ same / no effect
Acupuncture	☐ helped	☐ worsened	☐ same / no effect
Electric Stim/TENS Unit	☐ helped	☐ worsened	☐ same / no effect
Heat/Hot Packs	☐ helped	☐ worsened	☐ same / no effect
Cold Therapy/Cold Packs/Ice	☐ helped	☐ worsened	☐ same / no effect
Cognitive Therapy	☐ helped	☐ worsened	☐ same / no effect
Brace Support	☐ helped	☐ worsened	☐ same / no effect

IMAGING – *please indicate which of the following tests you have completed, include body part, facility, and date of study.*	
☐ X-ray	Date:
☐ MRI	Date:
☐ CT Scan / CT Myelogram / CT SPECT Scan	Date:
☐ Other: ☐ No imaging has been completed.	Date:

ALLERGIES – *please list below.*

☐ No known drug allergies.

CURRENT MEDICATIONS – please include name, dosage, and frequency.

☐ Not currently taking any medications.

REVIEW OF SYSTEMS – *please mark the following condition(s)/disease(s)/symptom(s) you have been treated for.*					
Cardiovascular:	☐ hearing problems	☐ arthritis	☐ measles	☐ decreased urine	***Neurological:***
☐ bleeding disorder	☐ nosebleeds	☐ asthma	☐ migraines	☐ flank pain	☐ anxiety
☐ blood clots	☐ sinus problems	☐ breast lump	☐ mononucleosis	☐ increased frequency	☐ depression
☐ chest pain	**Eyes:**	☐ bronchitis	☐ multiple sclerosis	☐ painful urination	☐ dizziness
☐ fainting	☐ cataracts	☐ cancer	☐ mumps	***Musculoskeletal:***	☐ headaches
☐ high blood pressure	☐ glaucoma	☐ chemical dependency	☐ osteoporosis	☐ ankle pain	☐ seizures
☐ low blood pressure	☐ recent visual changes	☐ chicken pox	☐ pacemaker	☐ elbow pain	☐ tremors
☐ palpitations	***Gastrointestinal:***	☐ diabetes	☐ pinched nerve	☐ foot pain	***Respiratory:***
Constitutional:	☐ abdominal cramps	☐ emphysema	☐ pneumonia	☐ hip disorder	☐ coughing
☐ chills	☐ acid reflux	☐ epilepsy	☐ prostate problem	☐ joint stiffness	☐ shortness of breath
☐ difficulty sleeping	☐ constipation	☐ fibromyalgia	☐ psychiatric patient	☐ joint swelling	☐ wheezing
☐ easy bruising	☐ diarrhea	☐ fractures	☐ rheumatoid arthritis	☐ knee injury	***Other:***
☐ fatigue	☐ nausea/vomiting	☐ gout	☐ stroke	☐ low back pain	
☐ fevers	***General:***	☐ heart disease	☐ skin problem	☐ mid-back pain	
☐ low sex drive	☐ AIDS/HIV	☐ hernia	☐ thyroid problem	☐ muscle spasm	
☐ weight gain	☐ alcoholism	☐ herniated disc	☐ vaginal infection	☐ neck pain	
☐ weight loss	☐ allergies	☐ high cholesterol	☐ venereal disease	☐ poor posture	
Ear/Nose/Throat/Neck:	☐ anemia	☐ kidney disease	***Genitourinary/***	☐ scoliosis	
☐ dental problems	☐ anorexia	☐ liver disease	***Nephrology:***	☐ shoulder pain	
☐ earaches	☐ appendicitis	☐ metal implant	☐ blood in urine	☐ wrist pain	

PAST MEDICAL/SURGICAL HISTORY – *please list any other major illnesses, injuries, or conditions.*	
☐ No significant medical history. ☐ No previous surgical history.	Date:
	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY – *please describe significant medical history for first-degree relatives.*
☐ No significant medical family history.

SOCIAL HISTORY		
Alcohol: ☐ never used	☐ current user—approximately how many drinks per week?	☐ history of alcoholism
Illegal/Illicit Drug(s): ☐ never used	☐ current user—*please indicate drug and duration of usage.*	☐ former user—quit date:
Tobacco/Smokeless Tobacco: ☐ never used	☐ current user—packs per day, and for how long?	☐ former user—quit date:

The completed information is accurate to the best of my knowledge.	
Patient Signature	Date

Please complete this paperwork in its entirety. We rely on its completeness to provide you with the best possible care.

To be filled out by patients involved in motor vehicle accidents

History of Injury:

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

Location: (street name) _____

Your vehicle was: ☐ Auto ☐ SUV ☐ pickup ☐ Van ☐ motorcycle ☐ bicycle ☐ Other: _____

Model, Make and Year of your vehicle: _____

Model, Make and Year of other Vehicle: _____

Was the impact from: ☐ the front ☐ the right side ☐ the left side ☐ the rear

You were the:

☐ Driver ☐ Passenger in front Passenger in rear: ☐ Left ☐ Middle ☐ Right

☐ Motorcycle Rider ☐ Pedestrian ☐ Other: _____

Were you wearing a seatbelt? ☐ Yes ☐ No any bruising? Where _____

Did your airbags deploy ☐ No ☐ Yes (☐ steering wheel ☐ dash board ☐ door ☐ side curtain)

At the time of impact your vehicle was:

☐ Slowing Down ☐ Stopped ☐ Constant Speed ☐ Changing Lanes

☐ Making U turn ☐ Making turn ☐ Gaining Speed ☐ Other: _____

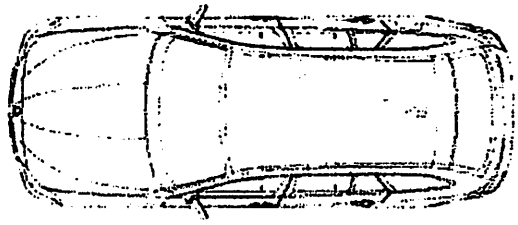
After the crash, your vehicle did the following:

☐ Kept going straight, not hitting anything ☐ Spun around, not hitting anything

☐ Kept going straight, hitting vehicle in front ☐ Spun around, hitting another vehicle

☐ Was hit by another vehicle ☐ Hit curb or object

On collision, your vehicle was struck at:

front  back

During impact, what any part of your body was struck where?

BODY PART	OBJECT YOU HAD CONTACT WITH
☐ head	☐ windshield or side window
☐ face (cheek, nose, lip)	☐ stirring wheel
☐ shoulder	☐ dashboard
☐ elbows	☐ head rest
☐ arm/hand	☐ door
☐ front chest wall	☐ back of front seat
☐ side chest wall	☐ roof
☐ hip	☐ other: _____
☐ knee	
☐ leg/ foot	
☐ other: _____	

Draw a line; which body part struck what part of the vehicle

Staff Member: write brief description of accident:

To be filled out by patients involved in motor vehicle accidents

After the Accident:

Did you loose consciousness? ☐ No ☐ Yes, if yes, ☐ Momentarily ☐ Several minutes ☐ other_____

Did the paramedics treat you at the site of the accident? ☐ No ☐ Yes _____

Did you go to the Hospital? ☐ No ☐ Yes, if yes, immediately? When? _____

How did you get to the Hospital? ☐ Ambulance ☐ Private transportation ☐ other _____

Were you admitted to the Hospital? ☐ No ☐ Yes Date of release: _____

Name of Hospital: _____

What discharge diagnosis did they give you? Sprain/Strain, Concussion, Contusion, Fracture?_____

Is there a Police report? _____

Which Doctors have you seen after the accident?

Chiropractor Dr. _____ Dates of service _____

Internist/Family Doctor Dr._____ Dates of service _____

Orthopaedic Surgeon/Neurosurgeon Dr._____ Dates of service_____

Other Specialist Dr._____Dates of Service_____

What diagnostic studies have you received since this accident? **(please specify)**

☐ X-rays of _____ ☐ MRI of _____ ☐ CT scan of _____EMG/NCV_____

What treatments have you received since this accident? **(please specify)**

☐ Chiropractic ☐ Physical Therapy ☐ Massage ☐ Acupuncture ☐ Other: _____

Which of the therapies gave you relief? _____ How much relief? _____

For how long?_____ Did your activity improve? _____

Did you have any accidents, injuries or pain problems prior to this accident? **YES NO**

PRIOR INJURIES, SYMPTOMS, OR TREATMENT BEFORE CURRENT INJURY/ACCIDENT

Date/Type of Injury/PainProblem/s:_____

Type of Treatment:_____

☐ Chiropractor ☐ Physical Therapy ☐ Massage ☐ Acupuncture ☐ Injections ☐ Surgery

☐ Other: _____

Have you recovered from your previous accident/injury? ☐ Yes ☐ No

List symptoms you have from your first accident/injury:_____

_____

To be filled out by patients involved in motor vehicle accidents

Please check all that **apply to your daily living activities** because of the accident:

I have pain:

- ☐ dressing
- ☐ taking a shower
- ☐ laying in bed
- ☐ sitting in couch/chair
- ☐ sleeping
- ☐ riding in car
- ☐ normal things have become a chore
- ☐ driving
- ☐ reading
- ☐ writing
- ☐ cooking
- ☐ opening doors
- ☐ exercising
- ☐ _____
- ☐ I have pain doing nothing
- ☐ playing with children
- ☐ going out with friends
- ☐ sexual activity
- ☐ eating
- ☐ _____

Are you currently working? ☐ No ☐ Yes If yes, what is your occupation? _____

Where do you work? _____

Please check all that **apply to you work** because of the accident:

- ☐ I'm still working but I'm in pain
- ☐ sitting at work hurts
- ☐ pushing/pulling at work hurts
- ☐ kneeling/bending at work hurts
- ☐ i cannot concentrate at work as well
- ☐ I lost job security
- ☐ I feel sleepy at work
- ☐ I feel tired at work
- ☐ I can't take time off work because I would lose my job
- ☐ I am unable to do my job as well before the accident
- ☐ I keep working so I don't lose my status at work
- ☐ using the computer hurts
- ☐ I am earning less than before the accident
- ☐ I am unable to do my my job as before the accident
- ☐ _____
- ☐ _____

☐ I take unpaid/ paid time off to go to medical appointments

☐ I work for the same company but have been assigned different duties/ light duty

☐ I have missed _____ days/months off work because of the accident

Please list all other activities that you are not able to do because of the accident:

_____

_____

_____

_____