Personal Injury Intake Paperwork CheckList X

For Staff Use Only

1)Patient Payment/Insurance Information ☐
(Includes Responsible Party Information,
Case #, Medpay Info, Attorney Info, Etc.)

2)Patient Signed Lien ☐

3)Attorney Signed Lien ☐

4)Patient Intake/History ☐

Office Coordinator/Manager Please Sign Once ALL ABOVE is completed

X _____ Date _____

PATIENT INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Height _____ Weight _____ Dominant Hand? R L

Address _____ City _____ Zip _____

Phone (cell) _____ Phone (other) _____

email _____ DL# _____

Health Insurance Company _____ Policy# _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Car Insurance Company _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

What Medical Payments Coverage? _____ What Uninsured Motorist Coverage? _____

What Law Firm Represents You? _____

Address _____ City _____ Zip _____

Your Lawyer's Name? _____ Phone _____

Name of Insured on your Car Policy _____ For office use only Patient #

Date of Loss/Accident? _____ Date you first saw *any* Doctor after accident _____

Cost of all medical treatment since the accident? $ _____

How much income have you lost since the accident $ _____

What is the property damage (repair amount) of your car? $ _____

Name of your Personal M.D. _____ Phone _____

Address _____ City _____ Zip _____

Write any Ambulance, Hospital, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident

Name	Type	Phone#	Amount of Bill	For office use only Records Rec'd

Please use other side of page to write additional doctors & hospitals

Notice of Provider's Lien

Provider Name and Address: **Attorney/Insurance Carrier:**

_____ _____

_____ _____

_____ _____

RE: Patient Records and Provider's Lien For _____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, etc..., of myself in regards to the accident/illness which occurred/began on _____.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien to my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered me that this agreement is made solely for said doctor's additional protection and in consideration of his/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. All requested fee reductions will be considered, however, only written acceptance signed by doctor will be valid. All oral discussions concerning fee reductions are hereby expressly declared non-binding.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Patient Signature: _____ **Dated:** _____

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 sums from any settlement, judgment or verdict, as may be necessary to adequately protect said doctor above-named. Attorney agrees attorney's status as trustee for clients funds will change from trustee to debtor if attorney: 1) does not pay directly for clients entire medical treatment upon settlement or, if written fee reduction is allowed by doctor, the reduced amount; 2) releases/forwards clients settlement funds directly to client without paying the doctor, requiring doctor to seek payment from client rather than attorney, or 3) refuses to withhold the entire amount of doctor's bill from settlement prior to disturbing funds to client due to a fee dispute with doctor.

Attorney's Signature: _____ **Dated:** _____

Attorney, please sign, date, and then promptly return this form to doctor's office. Keep one for your records.

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

SEA VIEW / COAST VIEW
CHIROPRACTIC

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Thank you in advance for taking the time to complete this form, this will help us to better assess all of your pain concerns and provide you with the best treatment.

NAME: _____ DATE: _____

Date of Injury: _____ Age: _____

Accident Details:

1. What kind of vehicle were you in?:
   Year - _____
   Make - _____
   Model - _____

2. Where were you seated? (circle): Driver / Front passenger / Rear left / Rear right

3. Were you wearing your seat belt? (circle): Yes / No

4. Did the airbags deploy? (circle): Yes / No

5. What was your body position at impact? (circle):

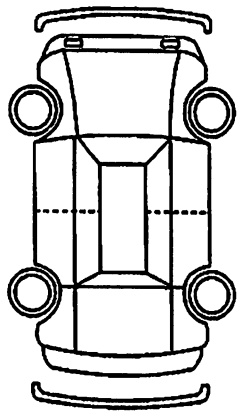
-Looking straight / Looking right / Looking left / _____

-Both hands on wheel / Right hand on wheel / Left hand on wheel / Hands in lap

-Right foot on brake / Right foot on gas / Left foot on floorboard / Both feet on floorboard

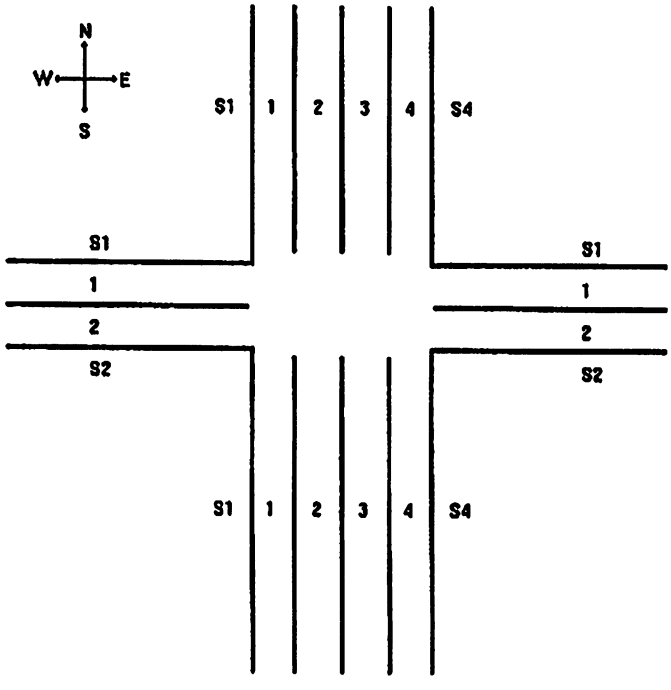
6. Where was the damage to your vehicle?:

Front: Driver Side Passenger Side



7. What kind of vehicle struck you?: _____

8. If possible, please roughly draw out what happened in the accident:



9. How fast was your vehicle traveling? (approximately): _____ mph

10. How fast was the other vehicle traveling? (approximately): _____ mph

11. Were you prepared for the impact, did you brace yourself? (circle): Yes / No

12. Did you lose consciousness? (circle): Yes / No

13. Were you in a daze, felt dizzy, disoriented, confused, etc ?. (circle): Yes / No

a. How long? _____ (ex. couple of seconds, 5 minutes, etc.)

If you answered YES to either question 12 or 13, please fill out question 13a

14. Where did you go for medical treatment?: _____

15. Were you taken by ambulance? (circle): Yes / No

13a. 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? (please list)

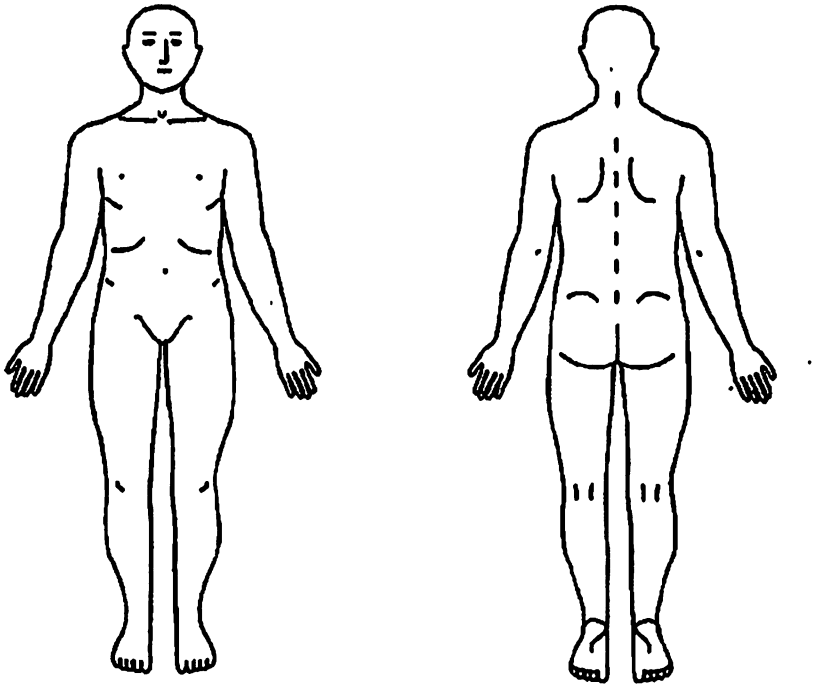
1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

Please take a moment to specifically identify your pain:

B2. Pain drawing

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	—	INC Sensitivity	0000
Constant	xxx	Sharp Twinge	////
Throbbing Ache	xxx		



What is your pain level at rest? (circle):

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

What is your pain level with activity? (circle):

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

How would you describe your pain? (circle):

Deep-pressure	Tightness	Spasms
Tingling	Numbness	Pinprick
Burning	Sharp-shooting	Stabbing

Is your pain (circle): Constant Intermittent

Since the accident, is your pain (circle): Unchanged Worse Better

What makes your pain worse? (circle):

Activity - Bending / Lifting / Walking / Sitting / _____

What makes your pain better? (circle):

Medications / Ice / Heat / Chiropractic / Rest / _____

Do you have any weakness? (circle): Yes / No --- +/or numbness? Yes / No

-If yes, where (circle): Left: Arm Leg --- Left: Arm Leg
Right: Arm Leg --- Right: Arm Leg

Do you have any loss of control or changes of your bowel or bladder? (circle): Yes / No

What treatments have you had following this accident? (circle):

Physical therapy	Heating pad	Ice pack	Injections	Chiropractic
Epidural injections	Surgery	Massage	Medications	Acupuncture

How has this accident affected your life?

_____

_____

Have you missed work? (circle): Yes / No

-If yes, how much: _____

-Have you returned to work?d (circle): Yes / No

-Have you **EVER** been in another **motor vehicle, work or any other type of injury?**

1. _____

2. _____

3. _____

MEDICAL CONDITIONS (Please list: such as diabetes, depression, gastric reflux):

_____

_____

MEDICATIONS (Tylenol, ibuprofen, Motrin, Alleve):_____

_____

SURGERIES:_____

_____

ALLERGIES: _____

FAMILY HISTORY:

FATHER – age ____, alive (circle): Yes / No

- medical conditions:_____

MOTHER – age ____, alive (circle): Yes / No

- medical conditions:_____

SOCIAL HISTORY:

Tobacco use (circle): Yes / No
Alcohol use (circle): Yes / Social / No
Drug use (circle): Yes / No

REVIEW OF SYSTEMS: *(mark only if positive)*

General-	**Skin-**	**Head-**	**Ears-**
◻ Weight loss or gain	◻ Rashes	◻ Headache	◻ Decreased hearing
◻ Fatigue	◻ Dryness	◻ Head injury	◻ Ringing in ears
◻ Fever or chills	◻ Lumps		◻ Earache

Eyes-	**Nose-**	**Neck-**	**Cardiovascular-**
◻ Glasses or contacts	◻ Discharge	◻ Lumps	◻ Chest pain
◻ Blurry or double vision	◻ Itching	◻ Swollen glands	◻ Tightness
◻ Flashing lights	◻ Nosebleeds		◻ Palpitations

Respiratory-
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Painful breathing

Gastrointestinal-
- ☐ Constipation / Diarrhea
- ☐ Change in appetite
- ☐ Nausea

Urinary-
- ☐ Increased Frequency
- ☐ Incontinence
- ☐ Blood in urine

Musculoskeletal-
- ☐ Muscle or joint pain
- ☐ Redness of joints
- ☐ Swelling of joints

Neurologic-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures

Psychiatric-
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss

Thank you!

Office use: _____

****IF PATIENT MISSES THEIR SCHEDULED TREATMENT WITH DR. HUYNH OR THERAPY APPOINTMENTS (Exam: Massage Therapy) WITHOUT 24 HOUR NOTICE TO OUR STAFF THEY MAY BE SUBJECT TO A $25.00 Charge.**

Patient Signature _____

DATE: _____