INITIAL EVALUATION – Automobile Accident

LAST NAME: ____________________ FIRST NAME: __________________ MI: ____ Date: ___________________

What brings you into our office? ☒ **Automobile Accident**

When did this accident happen? ________________________________

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear end ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What is the position of the headrest: ☐ Even with top of my head
☐ Even with bottom of my head
☐ Middle of neck

Did you strike anything inside the vehicle? ☐ Yes ☐ No

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What inside your vehicle did you strike?

□ Airbag	□ Armrest	□ Center Console	□ Dashboard	□ Gear shift lever/knob
□ Headrest	□ Rearview mirror	□ Roof	□ Rear window	□ Seatback
□ Side door	□ Side window	□ Wheel	□ Windshield	
□ Other:____________				

Immediately after the accident, did you feel dazed? □ Yes □ No

Did you lose consciousness? □ Yes □ No

Which way was your head turned during the accident?
□ Facing straight forward □ Turned to the right □ Turned to the left

Was your head injured? □ Yes □ No

Immediately after the accident, did you experience: □ Headache □ Neck Pain □ Low Back Pain

Did you see another doctor before coming here? □ Yes □ No

Did you go to a hospital after the accident? □ Yes □ No If yes, which hospital? __________________

How did you get to the hospital? □ Ambulance □ Drove self □ Somebody else □ Police

Were any of the following tests performed at the hospital?
□ X-Rays □ MRI □ CT Scan □ Lab Work

Do you feel your condition is: □ Improving □ Staying the same □ Getting worse

Have you lost time from work? □ Yes □ No

Can you perform physical work activities: □ Yes □ No

If no, because of: □ Pain □ Weakness □ Stress

Can you go to sleep without problems? □ Yes □ No

Do you awaken because of pain? □ Yes □ No

Did you have sleep problems before? □ Yes □ No

Activities of Daily Living Please select all activities which you are currently experiencing problems:

□ Seeing	□ Tasting	□ Smelling	□ Eating	□ Hearing	□ Insomnia
□ Dressing	□ Reading	□ Typing	□ Writing	□ Grasping	□ Using the toilet
□ Standing	□ Leaning	□ Walking	□ Stooping	□ Squatting	□ Loss of sexual drive
□ Bending	□ Twisting	□ Carrying	□ Lifting	□ Pushing	□ Restful sleeping
□ Sitting	□ Driving	□ Sports	□ Exercising	□ Reclining	□ Loss of concentration
□ Irritable	□ Riding in car	□ Air travel	□ Climbing	□ Pulling	□ Changes in personality
□ Grooming	□ Pinching	□ Kneeling	□ Reaching	□ Nervous	□ Tactile feeling

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□ Bathing □ Holding

Past Medical History Please select all conditions that you have had or are currently having:

□ None	□ Other	□ Abdominal pain	□ Weight gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□Chest pain	□Chronic cough	□ Chronic sinusitis
□ Colitis	□ Constipation	□ Convulsions	□COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty in swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□Excessive thirst	□Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ High Blood Pressure	□ High cholesterol
□ High PSA	□ High triglycerides	□ Hypertension	□ Irregular menstrual flow	□ Irritable colon
□ Jaw pain	□ Kidney disorders	□ Kidney stones	□ Liver / Gallbladder Problems	□ Loss of appetite
□ Loss of bladder control	□ Low back pain	□ Lung disease	□ Mental Disease	□ Mid back pain
□ Muscular in coordination	□Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□Prostate problems	□ Rapid heartbeat	□ Renal disease	□Rheumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	□ Swelling/stiffness joints	□Thyroid disease of
□Tinnitus/ ear noises	Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
□ Wrist pain				

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Family History Please select all conditions that run in your family:

□ None	□ Other	□ Abdominal pain	□ Weight Gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□ Chest pain	□ Chronic cough	□ Chronic Sinusitis
□ Colitis	□ Constipation	□ Convulsions	□ COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□ Excessive thirst	□ Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ HBP	□ High cholesterol
□ High PSA	□ High triglycerides	□ Hypertension	□ Irregular menstrual flow	□ Irritable colon
□ Jaw pain	□ Kidney disorders	□ Kidney stones	□Liver/Gallbladder problems	□ Loss of appetite
□ Loss of bladder control	□ Low back pain	□ Lung disease	□ Mental disease	□ Mid back pain
□ Muscular coordination	□ Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□ Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□ Prostate problems	□ Rapid heartbeat	□ Renal Dx	□ Rheumatoid arthritis
□ Scoliosis	□ Shoulder pain	□ Stroke	□ Swelling/stiffness of joints	□ Thyroid disease
□ Tinnitus/ ear noises	□ Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
	□ Wrist pain			

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Surgical History

Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

Medications

Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies

Please select all items that you are allergic to:

☐ None	☐ Chemical	☐ Environmental	
☐ Food	☐ Medication	☐ Seasonal	☐ Other

Social History

Please answer the following

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? ________

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

PERSONAL INJURY LIEN

Patient Name: ____

Date of Accident: ____

I hereby authorize and direct:

Name of Attorney: ______________________________

Attorney's Address: ______________________________

Attorney's Phone: ______________________________

Attorney's Signature: ______________________________

to pay directly to **Rock Family Chiropractic** such sums as may be due and owing for treatment rendered to me, both by reason of this accident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately give a lien on my case any and all proceeds of any settlement, the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to **Rock Family Chiropractic** for all medical bills submitted for services rendered to me and that this agreement is made solely for **Dr. Ryan Rock, D.C.** for additional protection and in consideration of awaiting payment. I further understand that such payment is to eventually recover said fee.

______________________________ ______________

Patient's Signature Date

______________________________ ______________

Countersigned/Witnessed by Staff Date

Insurance Authorization

DR RYAN M ROCK, DC
1402 CHURCH ST. STE E
EUDORA, KS 66025

TELEPHONE: (785) 542.2118
FAX: (785) 542.1164

Signature on File

Please read and check each box:

( ) I authorize use of this form on all of my insurance transmissions.

( ) I authorize release of information to all of my insurance carriers.

( ) I understand I am responsible for my bill.

( ) I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier.

( ) I authorize payment direct to my doctor.

( ) I permit a copy of this authorization to be used in place of the original.

I UNDERSTAND THAT IF MY CONDITION IS DUE TO AN ACCIDENT (AUTO, ON THE JOB, OR AT HOME) THE INSURANCE INFORMATION THAT I HAVE GIVEN AT THIS TIME IS THE INSURANCE THAT I WISH TO USE FOR THIS CLAIM. I WILL NOT HOLD ROCK FAMILY CHIROPRACTIC RESPONSIBLE FOR FILING ANY OTHER CARRIERS OTHER THAN WHAT I HAVE INDICATED. IF I HAVE NOT SUPPLIED ANY INSURANCE INFORMATION I WILL NOT HOLD ROCK FAMILY CHIROPRACTIC ACCOUNTABLE FOR FILING ANY CLAIMS TO ANY INSURANCE CARRIER.

Name____
Please Print

Signature________________________ Date____________________

DOCTOR'S LEIN

Dr. Ryan Rock, DC
1402 Church Street, Suite E
Eudora, KS 66025
Telephone (785) 542-2118
Fax (785) 542-1164

____

(Attorney/Insurance Company)

____

(Attorney/Insurance company address) (Telephone)

____

(City, State, and Zip Code)

____

(Patient's Name and Date of Birth)

I hereby authorize the above doctor to disclose a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to the accident in which I was involved. This authorization has no expiration date.

- I understand that I have the right to revoke this authorization by sending a written letter to Dr. Rock, except to the extent that Dr. Rock has already taken action in reliance upon this authorization. ________
- I understand that the information disclosed under this authorization may be redisclosed by attorney(s)/insurance company(s) and that the privacy or my information is no longer protected by the federal privacy rule once it is disclosed to attorney(s) and or insurance company(s) ________
- I understand that I may inspect or copy the information to be disclosed except in those circumstances when inspection or copying of my information may be lawfully denied under federal law. ________
- I also understand that I may refuse to sign this authorization and that Dr. Rock will not condition treatment on my providing authorization for this disclosure. ________

I hereby authorize and direct you, attorney(s)/insurance company(s) to pay directly to Dr. Rock such sums as may be due and owing him for professional services, supplies, items, reports, and proceedings rendered to me or on my behalf by reason of the afore said accident and by reason of any other bills that are due owing to Dr. Ryan Rock, DC and to without such sums from any settlement judgement or verdict as may be necessary to adequately protect and fully compensate Dr. Rock.

I hereby give a lien on my case to Dr. Rock against any and all proceeds of any settlement, judgement or verdict be paid to myself as the result of the injuries for which I have been treated for injuries incurred therewith.

- I fully understand that I am directly and fully responsible to Dr. Rock for all professional bills submitted by him for services rendered and that this agreement is made solely for Dr. Rock's additional protection and in consideration of pending payment.
- I hereby waive my right to make any objections regarding the enforceability or appropriateness of this agreement. I also further understand that such payment is not contingent on any settlement judgement or verdict by which I may eventually recover said fee.

(Signature of Patient or Guardian) (Date)

(Please print name of Patient or Guardian)

(Address) (Telephone)

(City, State, and Zip Code)

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal on the ____ day of __________,20___.

Notary Public

My commission expires:

Attorney(s)/insurance company(s): Please sign, date, and return this document to the doctor's office named above. Keep a copy for your records.

The undersigned being attorney(s)/insurance company(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above.

(Attorney/Insurance Company Signature) (Date)

(Please print name and title)