PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Patient Name:	**Today's Date:**
Address:	**Date of Collision**:
City/State/Zip:	Home Telephone:
Date Birth: **Age:**	Work Telephone:
Height: **Weight:**	Cell phone:
Social Security No: -- --	Employer's Name:
Drivers License No:	Employer's Address:
Marital Status (Circle): Single, Married, Divorced, Widowed	Job Title:

Time of injury _____ ☐ AM ☐ PM City where crash occurred: _____
Was the street wet or dry? ☐ Wet, ☐ Dry. Street (location) where crash occurred:_____
What is the estimated damage to your vehicle? $ _____
Who made damage estimates on your vehicle? _____
Who owns the vehicle you were involved in: _____
Did the police come to the accident scene? ☐ Yes, ☐ No
Did the police make a written report? ☐ Yes, ☐ No
Were any photographs taken of your vehicle? ☐ Yes, ☐ No If yes, who took them: _____
Were you treated at any other facility prior to coming here? ☐ Yes, ☐ No If so, where _____
Were you taken to the hospital in an ambulance? ☐ Yes, ☐ No How did you get to the hospital? _____
Have you had any x-rays taken since the accident? ☐ Yes, ☐ No Describe type _____
MRI's or CT Scans_____ ☐ Yes, ☐ No: If so where, and when?_____
Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):
_____

DESCRIBE HOW THE CRASH HAPPENED BELOW
_____
_____
_____

IMPORTANT: PLEASE CHECK ALL PRESENT SYMPTOMS:

HEAD:
- ☐ Headache
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Pain or ringing in ears

NECK:
- ☐ Pain in neck with whiplash
- ☐ Popping/grinding in neck
- ☐ Increasing Pain in neck w/movement

SHOULDERS:
- ☐ Pain in shoulders (L / R)
- ☐ Tension in shoulders
- ☐ Can't raise arms (L/R)
- ☐ Muscle spasms in shoulders

EYES / Vision : (Explain)
_____
_____
_____

ARMS & HANDS:
- ☐ Hands cold
- ☐ Loss of grip strength (L / R)
- ☐ Sensation of pin/needles(L/R)
- ☐ Numbness in Arms (L/R)
- ☐ Numbness in fingers (L/R)
- ☐ Fingers go to sleep
- ☐ Pain in fingers/hands
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Pain in wrist (L/R)
- ☐ Pain in

MID-BACK:
- ☐ Pain between shoulder blades
- ☐ Pain in Mid-back
- ☐ Muscle Spasms
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back

CHEST:
- ☐ Chest pain
- ☐ Pain around ribs
- ☐ Breast pain

LOW-BACK:
- ☐ Low back pain
- ☐ When sitting
- ☐ When lifting
- ☐ When lying down/sleeping
- ☐ When walking
- ☐ Muscle spasms

HIPS, LEGS & FEET:
- ☐ Pain in buttocks
- ☐ Pain in hips
- ☐ Pain down legs
- ☐ Pain in knees
- ☐ **Other pain: (Explain)**

_____

Signature of responsible party (Patient or Parent)_____**Date** _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.
0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 **10**

☺ Completely **able** to function ☹ Totally **unable** to function

1. **FAMILY/HOME RESPONSIBILITIES**: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.)
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

2. **RECREATION**: hobbies, sports, and other similar leisure time activities.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

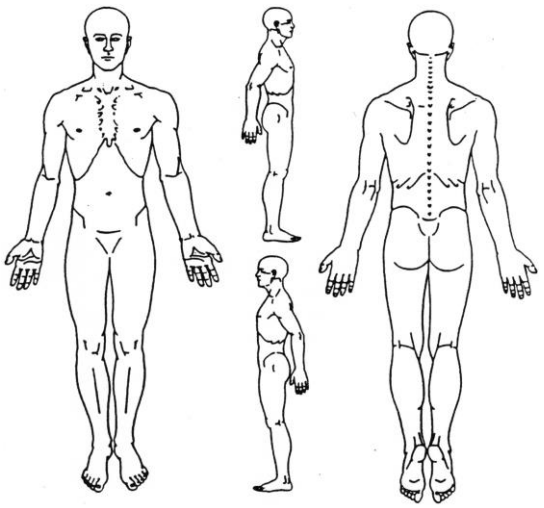
3 **SOCIAL ACTIVITY**: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

4. **OCCUPATION**: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

5. **SELF CARE**: activities that involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

6. **LIFE SUPPORT ACTIVITY**: basic life supporting behaviors such as eating, sleeping, and breathing.
   Full Function- 0 1 2 3 4 5 6 7 8 9 10 -Total Dysfunction

PLEASE MARK YOUR AREAS OF PAIN IN THE FIGURES BELOW.



The Back, Neck and Headache Relief Center at Vacaville Chiropractic
Dr. John F. Knych, D.C.
(707) 448-3008

Patient Signature_____**Date**_____

MOTOR VEHICLE CRASH FORM

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all areas that apply to you.

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending crash and relaxed before the collision.
☐	You were aware of the impending crash and braced yourself.
☐	Your body, torso, and head were facing straight ahead.
☐	***You had your head and/or torso turned at the time of collision:*** ☐ Turned to left, ☐ Turned to right Describe how far you were turned/twisted and why?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback
☐	Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting
☐	Were you trying to restrain an occupant in the car?

COLLISION DESCRIPTION-TYPE –Please circle ALL that apply to your Crash
Single-Car Crash, Two Vehicle Car Crash**, Three or More Vehicles,** Rear-end crash**, Side Crash,** Rollover**,**
Head-on crash, Hit guard Rail, tree or object, **Ran off of road,** Other (Describe): _____

_____

INDICATE YOUR SEATING POSITION: (Circle which applies to you).
I was the: Driver, Front Passenger, Left Rear Passenger (behind driver), Right rear Passenger
Who else was in the car with you, Please describe each:_____

_____

DESCRIBE YOUR VEHICLE: by circling all that apply to your car:
Small economy car, mid-sized car, large sized car, pick-up truck, Van, Sports Utility Vehicle, Large Truck, Bus or Semi-Truck, Station Wagon or Other (Describe):_____
Your car's make, model and year_____

DESCRIBE THE CAR THAT HIT YOU:
Small economy car, mid-sized car, large sized car, pick-up truck, Van, Sports Utility Vehicle, Large Truck, Bus or Semi-Truck, Station Wagon,
Other (Describe): The other car's make, model and year (whatever you know) _____

AT THE TIME OF IMPACT YOUR VEHICLE WAS: please circle the best description:
Slowing down, Stopped, Gaining Speed, Moving at a Steady Speed,
Other_____

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:
Slowing down, Stopped, Gaining Speed, Moving at a Steady Speed, Unknown Speed,
Other_____

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object other than car
		☐	Other: describe below -

_____

CIRCLE **ANY OF THE FOLLOWING VEHICLE PARTS THAT WERE BROKEN, BENT, OR WERE DAMAGED IN YOUR CAR:** Windshield, Steering Wheel, Dash, Seat frame, side rear window, mirror, knee bolster, other:_____

Patient Signature:_____**Date**:_____

ALL TYPES OF COLLISIONS: Indicate those relevant to your case.

YES	NO	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash?
☐	☐	Were you intoxicated (alcohol) at the time of crash?

YES	NO	**SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:**
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap and Shoulder Strap, ☐ Lap belt only
☐	☐	Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned (Use time clock face as your reference point) Left hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere Right hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY: Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint
☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

Please indicate how your <u>head restraint</u> was positioned at the time of crash (if present):

☐ At the top of the back of your head ☐ Midway height of the back of your head
☐ Lower height of the back of your head ☐ Located at the level of your neck
☐ Level of your shoulder blades

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:
Please **draw lines** from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield
Face	Side window
Shoulder	Side door
Arm/Elbow/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt
Hip/abdomen	Frame of car near windows
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

Bruising After the Crash

Did your body have any bruising (areas that were visibly black and blue) after the crash? Yes / No
If yes indicate where:_____

Patient Signature:_____ **Date:** _____

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage **for the vehicle you were in?**	☐ I have coverage ☐ Someone else has coverage. Indicate name and relationship of person policy is under:
How is this person related to you?	☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Have you reported this injury to your ins. carrier?	☐ Yes, ☐ No
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name:	
Claim Adjuster's Telephone Number:	Claim adjuster's Fax
Claim Number:	
Do you have an Insurance Deductible?	☐ Yes, ☐ No Deductible is: $
Do you know your Policy Limits for medical bills?	☐ Yes, ☐ No Limit is: $

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.* ***Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.***

It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Patient Signature:_____ **Date:** _____