PERSONAL INJURY QUESTIONAIRE

Name _____ Phone ( )_____
Address _____ City_____ State_____ Zip_____
Birth Date _____ Sex: ( ) M ( ) F
Employer's Name_____ Work Phone ( ) _____
Employer's Address_____ City_____ State _____

Your Insurance Co. _____ Claim # _____
Agent's Name _____ Phone ( ) _____
Name on Policy (if other than self) _____Policy # _____

ATTORNEY:
Name _____ Phone ( ) _____
Address _____ City _____
State _____ Zip _____

NATURE OF ACCIDENT:
1. Date of accident _____
2. City of accident _____ Street of accident_____
3. Road conditions at the time of the accident: WET DRY ICY other:_____
4a. List the year, make and model of the vehicle **YOU** were in:
Year _____ Make _____ Model _____
b. Amount of damage_____
c. Was it drivable afterward? ( )Yes ( ) No

5a. What is the year, make and model of the **OTHER** vehicle?
Year _____ Make _____ Model _____
b. Amount of damage_____
c. Was it drivable afterward? ( )Yes ( ) No ( ) Unknown
6. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
7. Number of people in your vehicle_____ Were you wearing your seat belt? ( )Yes ( ) No
8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
9. Approximate speed of your car _____mph Other car _____mph
10. Were you knocked unconscious? ( ) Yes ( ) No
If yes, how long? _____
11. Did the Police make a report? ( ) Yes ( ) No
12a. Describe the accident _____
_____
_____
_____
_____
b. What was the position of your body and neck before impact? _____
_____
_____
c. What is the very next thing you remember after being hit? _____
_____

13. Did you have any physical complaints **BEFORE** the accident? ( ) Yes ( ) No
If yes, please describe:

14. Please describe how you felt **IMMEDIATELY** after the Accident: _____

15. What are your **PRESENT** complaints and symptoms? _____

16. Where were you taken after the accident? _____
17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, please list the doctor's name and address _____
What type of treatment did you receive? _____
18. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
19. Check the symptoms you have noticed since the accident:

( ) Headache	( ) Irritability	( ) Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Cold Hands
( ) Stiff Neck	( ) Dizziness	( ) Fatigue	( ) Loss of Balance	( ) Upset Stomach
( ) Sleeping Problems	( ) Head seems too heavy	( ) Depression	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Pins and Needles in Arms	( ) Visual problems	( ) Loss of Smell	( ) Cold Sweats
( ) Nervousness	( ) Pins and Needles in Legs	( ) Loss of Memory	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Numbness in Fingers	( ) Ringing in Ears	( ) Diarrhea	( ) Muscle Weakness

Other _____

20. Have you lost time form Work as a result of this accident? ( ) Yes ( ) No
If yes, what dates: from ____/____/____ to ____/____/____ *or* list dates _____
21. What activities at home / work can you no longer perform as before? _____

I attest that the above information
is true to the best of my knowledge. _____ _____
Signature Date

PATIENT HEALTH QUESTIONNAIRE - PAGE 2

If you have ever *had* a listed symptom in the *past*, please check that symptom in the *Past column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*.

Past	Present	
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Hand Pain
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Ankle or Foot
☐	☐	Jaw Pain
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting, Visual Disturbances, Nausea
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue

Present: Weight _____ pounds

Height ____ feet _____ inches

Past	Present	
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast Soreness/Lumps
☐	☐	Vaginal Discharge
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Please check any of the following that apply to you.

☐	☐	Tobacco use
☐	☐	Alcohol use
☐	☐	Birth Control Pills used
☐	☐	Medications (please list them) _____
☐	☐	Drug or Alcohol Dependence
☐	☐	Pregnancy
☐	☐	Surgical Procedures (please list them) _____
☐	☐	Coffee/Tea/Caffeinated Soft drinks, cups per day_____

Yes	No	
☐	☐	Do you have a permanent disability rating?

Location _____

Date rating received ____/____/____

Rating Percentage _____%

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Prostate Problems
☐	☐	Anorexia
☐	☐	Blood Disorder

Past	Present	Condition
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Ulcer
☐	☐	Kidney Stones
☐	☐	Bladder Infection
☐	☐	Kidney Disorders
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other_____

Patient's Signature:_____ Date:_____

Grand Lake Health Center...the Chiropractic Office of your choice.....

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at the Grand Lake Health Center we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
* Your photograph or testimonial may be used for public awareness and education.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Mark Wong

If you would like further information about our privacy policies and practices please contact: Dr. Mark Wong

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party

_____	_____
Personal Representative Printed	*Personal Representative Signature Date*

_____

Description of the authority to act on behalf of the patient.

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment. As a part of the analysis, examination, and treatment, you are consenting to the following procedures: joint manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural treatment/analysis, ultrasound, hot/cold therapy, vibromassage, cupping, Flexion/Distraction, myofascial therapy, cranial therapy, leg checks and challenges, taping, Other :

_____

_____

The risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray(s) if taken. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options. Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (For MINOR) *I hereby request and authorize Dr. Mark J. Wong, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: ____ _____ _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.*

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Mark J. Wong, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I also agree to make all scheduled appointments to the best of my ability in a timely fashion. If I am not able to make said appointment, I will call within 24 hours to cancel or reschedule the appointment. If I do not make such preparations I understand that I may be charged a $25.00 cancellation fee, which is not billable to insurance.

Patient Name: _____ Dated: _____

Signed: _____ Email: _____

Signature of Parent or Guardian if a minor: _____

Email will only be used for communication from my office and will never be shared without your consent.

Dr. Mark J. Wong, D.C _____ Dated: _____