Summit Chiropractic **Motor Vehicle Collision Questionnaire** **Dr. Jason Morris**

Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Social Security #_____

Occupation_____
Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
   _____
   _____
   _____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts: _____
   B. Visual Disturbance : yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
      % of time: ___ % of time: ___ % of time: ___ % of time: ___
   C. Dizziness: yes/no % of time: ____
   D. Anxiety: yes/no % of time: ____
   E. Depression: yes/no % of time: ____
   F. Difficulty Sleeping: yes/no

3. **Past Health History:**

   A. Please indicate if you have a history of any of the following:
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
   □ None of the above

   B. Previous Injury or Trauma:
   ______

   Have you ever broken any bones? Which?
   _____

   C. Allergies: ______

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Patient Name: _____ Date: _____

D. Medications:

Medication Reason for taking

_____
_____
_____
_____

E. Surgeries:

Date Type of Surgery

_____
_____
_____
_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____
_____
_____
_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____
Cause of parents or siblings death Age at death

_____
_____
_____

5. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **[name of doctor/clinic]** for services performed.

Patient or Guardian Signature _____
Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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Patient Name: _____ **Date:** _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

3b) Were you leaning forward at the time of impact? **Yes** / **No**

4) What type and year of vehicle were you in? _____

_____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type and year of vehicle struck yours?_____

_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

7) Did you feel pain immediately after the accident? **Yes** / **No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

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Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches /**
Muscle Relaxants / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above: _____

Your Auto Insurance Company: _____ Policy Number: _____
Make/Model/Year of your vehicle: _____
Name of Driver/Other Vehicle: _____ Make/Model/Year of other vehicle: _____
Driver/Other Vehicle Insurance Company: _____ Policy Number: _____
CLAIM NUMBER: _____

Do you have qualifying Medical Payment Benefits (MedPay) from your auto insurance? □ Yes □ No
Have you retained an attorney? □ Yes □ No Name: _____

_____ _____
Patient Signature Date

MECHANISM OF INJURY:

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According to Warner et al, when an automobile is struck from behind, a ramping effect is created, thereby causing the occupants of the automobile to move upward. This causes the headrest to now strike the head at a lower angle, creating a fulcrum for increased hyperextension of the neck. This increases the injury. **(Warner CY, Stother CE, James MB, Decker RL Occupant protection in rear-end collisions:II. The role of seat back deformation in injury reduction. 35th Stapp Car Crash Conference, 1991; SAE 912914)**

According to Mertz and Patrick, the unaware occupant is at a greater risk of injury. **(Mertz HJ, Patrick LM. Investigation of the kinematics and kinetics of whiplash. 1967; SAE 670919.)**

Radanov and Sturzenegger found that patients who had rotated or inclined head position were much more likely to have symptoms at 2 years post-injury than those with a straight-on head position. **(Radanov BP, Sturzenegger M. The effect of accident mechanisms and initial findings on the long-term outcome of whiplash injury. Journal of Musculoskeletal Pain 1996;4(4):47-59.)**

According to Luo and Goldsmith, a small car can experience much higher accelerations in a minor impact and therefore increase the injury. **(Luo Z, Goldsmith W. Reaction of a human head/neck/torso system to shock. Journal of Biomechanics 1991;24;7;499-510.)**

According to Luo and Goldsmith, the faster and heavier the rear car is moving, the more severe the forces placed on the occupant in the front car. **(Luo Z, Goldsmith W. Reaction of a human head/neck/torso system to shock. Journal of Biomechanics 1991;24;7;499-510.)**

According to Allen, Barnes and Bodiwala, shoulder belts are very effective at saving lives in auto accidents, but there is some evidence that they can actually cause more damage in a rear end collision. Because the body is held in place, the neck suffers worse hyperflexion. The cervical spine may also undergo a twisting motion from the head restraint, causing a more complex injury. **(Allen MJ, Barnes MR, Bodiwala GG. The effect of seat belt legislation on injuries sustained by car occupants. Injury: The British Journal of Accident Surgery 1985; 16; 471-476).**

A study by Radanov found that patients who reported pain immediately after their accidents were more likely to have pain at two years post-injury. It is generally recognized that patients with immediate symptoms are at a higher risk of long-term pain from whiplash. **(Radanov BP, Sturzenegger M, De Stefano G. Long-term outcome after whiplash injury. A two-year follow-up considering the features of injury mechanisms and somatic, radiologic and psychosocial findings. Medicine 1995; 74(5): 281-296.)**

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work	Reason for the difficulty	Duration

Job Description: _____

□ Lifting Increased Pain _____

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□ Bending	Increased Pain	_____
□ Sitting	Increased Pain	_____
□ Walking	Increased Pain	_____
□ Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School	**Reason for the difficulty**	**Duration**
□ Lifting	Increased Pain	_____
□ Bending	Increased Pain	_____
□ Sitting	Increased Pain	_____
□ Walking	Increased Pain	_____
□ Computer Duties	Increased Pain	_____
□ Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Domestic Duties	**Reason for the difficulty**	**Duration**
□ Vacuuming	Increased Pain	_____
□ Taking Care of Kids	Increased Anxiety	_____
□ Cleaning	Increased Pain	_____
□ Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	**Reason for the difficulty**	**Duration**
□ Yardwork	Increased Pain	_____
□ Transportation	Increased Anxiety	_____
□ Shopping	Increased Pain	_____
□ Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work	**Reason for the difficulty**	**Duration**

Job Description: _____

□ Lifting	Increased Pain	_____
□ Bending	Increased Pain	_____
□ Sitting	Increased Pain	_____
□ Walking	Increased Pain	_____
□ Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

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Patient Name: _____ **Date:** _____

Studies/School	**Reason for the difficulty**	**Duration**
□ Lifting	Increased Pain	_____
□ Bending	Increased Pain	_____
□ Sitting	Increased Pain	_____
□ Walking	Increased Pain	_____
□ Computer Duties	Increased Pain	_____
□ Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Loss of Enjoyment

Domestic Duties	**Reason for the difficulty**	**Duration**
□ Vacuuming	Increased Pain	_____
□ Taking Care of Kids	Increased Anxiety	_____
□ Cleaning	Increased Pain	_____
□ Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	**Reason for the difficulty**	**Duration**
□ Yardwork	Increased Pain	_____
□ Transportation	Increased Anxiety	_____
□ Shopping	Increased Pain	_____
□ Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	**Reason for the difficulty**	**Duration**
□ Social	_____	_____
□ Competitive	_____	_____
□ Regional	_____	_____
Other:	_____	_____

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