MOTOR VEHICLE COLLISION HISTORY

Name: ______________________________ Date: ____________

Insurance Company: ______________________ Policy Number: ________________________

Address: _____________________________ Name of Agent: ________________________

(Circle all that apply)

Have you retained an attorney? **No** **Yes** Name of Attorney: ________________________

COLLISION HISTORY:

Date of Collision: _____________________ Time of Collision: ______________ A.M. P.M.

Number of Vehicles Involved: ________________ Did you take pictures? **No** **Yes**

What type of vehicle were you in? Make/Model: ______________________Year: ________________

Were you driving? **No** **Yes** Was it your car? **No** **Yes** If not, whose? ________________

If you were a Passenger, where were you? **Front** **Back** **Right Side** **Left Side** Other: ______________

Seat belts on? **No** **Yes** Shoulder harness on? **No** **Yes** Did airbag deploy? **No** **Yes** Broken Seat? **No** **Yes**

Did your head hit the headrest? **No** **Yes** Position of headrest: **Low** **Mid** **High** **Absent**

Where were you looking on impact? **Forward** **Left** **Right** **Down** **Rear-View Mirror** **Over Shoulder**

Were you aware of the impending impact? **No** **Yes** Did you brace for impact? **No** **Yes**

Where is the damage on your vehicle? **Driver's Side** **Passenger Side** **Roof**

Front Left **Front Center** **Front Right** **Back Left** **Back Center** **Back Right**

Extent of Visible Damage: **Totaled** **Heavy** **Moderate** **Slight** **No Visible Damage**

Your vehicle movement prior to the collision: **Stopped** **Forward** **Backward** **Left Turn** **Right Turn**

Were other people in the car with you? **No** **Yes** Names and Addresses: ________________________

____

Were they injured? **No** **Yes** If yes, please explain: ____

____

What type of vehicle collided with the vehicle you were in? Make/Model:____________________________

Car **SUV** **Pick-up Truck** **Tractor Trailer** Other: ________________________

Where is the damage on their vehicle? **Driver's Side** **Passenger Side** **Roof**

Front Left **Front Center** **Front Right** **Back Left** **Back Center** **Back Right**

Extent of Visible Damage: **Totaled** **Heavy** **Moderate** **Slight** **No Visible Damage** **Unknown**

Your vehicle movement immediately prior to the accident: Stopped Forward Backward Left Turn Right Turn

Estimated Speed of Your Vehicle: __________ **Estimated Speed of Their Vehicle:** __________

What was the posted speed limit? ______ mph Type of road: **2 Lane** **4 Lane** **Gravel** **Tar**

Did any car need to be towed from the scene? **No** **Yes**

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Name: ________________________________

Did police arrive on the scene? **No** **Yes** What City, Township or Locality?________________________________

Was accident report made? **No** **Yes** Who was ticketed? ______________ For?________________________

____

Was it? **Daylight** **Night** **Dark** **Dawn** What were the weather conditions? ________________________

How long had you been in the car? ____________ What were the traffic conditions? ________________________

Did it happen at a/an: **Stop Sign** **Traffic Light** **Intersection** **Highway** **Other**

Did your vehicle strike anything after the initial impact? **No** **Yes** If yes: **Another Car** **Sign** **Tree**

Off the Road **Other:** ______________________________ **Size and Type**: ______________________

State how the accident happened in your own words: ____

____

____

____

GENERAL SYMPTOMS/INJURIES:

Did your body hit anything inside the vehicle? **No** **Yes** What part of your body hit what in the vehicle?____________

____

Did you receive an injury to the head, like a concussion or cut? **No** **Yes** Describe:________________________

Were you completely conscious after the impact? **No** **Yes** **Not Sure** Do you remember the impact? **No** **Yes**

Did EMS/ambulance arrive on scene? **No** **Yes** Was anyone from scene transported to the hospital? **No** **Yes**

Did you go to hospital, home, work or other? How?____

Were you hospitalized? **No** **Yes** If yes, where and for how long? ________________________________

Did you seek medical care after the collision? **No** **Yes** Describe: ________________________________

____

Where did you feel symptoms after the collision?____

Any other symptoms after the collision? ____

How have symptoms changed after the collision? ____

Have you had any time loss from work? **No** **Yes** If yes, from __________________ to ______________

Have you ever had to have any outside help? **No** **Yes** What type? ____________________________________

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: ____ Date: ____________________

RISK FACTOR ASSESSMENT QUESTIONNAIRE - INITIAL

Patient Name ____ Date _________________________

Instructions: Please answer every section, and mark in each section the ONE CHOICE which applies to you.

1. Where do you have pain? Check all appropriate sites.
   ( ) Neck ( ) Shoulders ( ) Upper back ( ) Lower Back ( ) Leg
2. How long ago did your current episode begin?
   ( ) Less than 2 weeks ago ( ) 2 weeks to < 8 weeks ago ( ) 8 weeks to < 3 months ago ( ) 3 months to < six months ago ( ) > 6 months ago
3. How many previous episodes required treatment?
   ( ) None ( ) 1 ( ) 2 ( ) 3 ( ) 4 or more
4. Have you been hospitalized or had surgery for the same or similar complaint before? ( ) Yes ( ) No
5. Please indicate your usual level of pain during the past week.
   No pain ____________________ worst possible pain
   0 1 2 3 4 5 6 7 8 9 10
6. How often would you say that you have experienced pain episodes, on average during the past 3 months? (Circle one number)
   Never ____________________ Always
   0 1 2 3 4 5 6 7 8 9 10
7. Does pain, numbness, tingling or weakness extend into your leg (from the low back) and/or arm (from the neck)?
   None of the time ____________________ All of the time
   0 1 2 3 4 5 6 7 8 9 10
8. During the last week, how often have you taken medication (such as aspirin, Motrin, Tylenol, or prescription medication) for your pain complaint?
   Not at all ____________________ 3 or more times a day
   0 1 2 3 4 5 6 7 8 9 10
9. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
   Delighted ____________________ Terrible
   0 1 2 3 4 5 6 7 8 9 10
10. How anxious (eg, tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you been feeling during the past week?
    Not at all ____________________ Extremely anxious
    0 1 2 3 4 5 6 7 8 9 10
11. How much have you been able to control (eg, reduce/help) your pain/complaint on your own during the past week?
    I can reduce it ____________________ I can't reduce it at all
    0 1 2 3 4 5 6 7 8 9 10
12. Please indicate how depressed (eg, down in the dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in the past week.
    Not depressed at all ____________________Extremely depressed
    0 1 2 3 4 5 6 7 8 9 10
13. How would you rate your general health?
    Poor ____________________ Excellent
    0 1 2 3 4 5 6 7 8 9 10
14. Do you smoke tobacco a pack a day or more? ( ) Yes ( ) No
15. An increase in pain is an indication that I should stop what I am doing until the pain decreased.
    Completely agree ____________________ Completely disagree
    0 1 2 3 4 5 6 7 8 9 10
16. Physical activity makes my pain worse?
    Completely disagree ____________________ Completely agree
    0 1 2 3 4 5 6 7 8 9 10
17. I can do light work for an hour?
    Can't do it because of pain problems Can do it without pain being a problem
    ____
    0 1 2 3 4 5 6 7 8 9 10
18. I can sleep at night.
    Can't do it because of pain problems Can do it without pain being a problem
    ____
    0 1 2 3 4 5 6 7 8 9 10
19. How physically demanding is your job (include housework if not employed outside the home)?
    Not at all demanding ____________________Very demanding
    0 1 2 3 4 5 6 7 8 9 10
20. Have you been disabled due to the same or similar pain/complaint in the last 12 months? ( ) Yes ( ) No
21. I should not do my normal work with my present pain.
    Completely disagree ____________________ Completely agree
    0 1 2 3 4 5 6 7 8 9 10
22. How well do you like your work?
    Not at all ____________________ Very much
    0 1 2 3 4 5 6 7 8 9 10
23. What kind of trouble at work do you think you will have sitting or standing 6 weeks from now?
    No trouble ____________________ Extreme trouble
    0 1 2 3 4 5 6 7 8 9 10
24. On a scale of 0 to 10, how certain are you that you will be working in 6 months?
    Very certain ____________________ Not certain at all
    0 1 2 3 4 5 6 7 8 9 10

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Patient Initials

ASSIGNMENT

I was involved in an accident on or around _______________(date) in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (referenced as "My Claim"). In consideration of the agreement of **Harmony Chiropractic Center, Inc.** (HCC) to delay billing me personally for medical treatment rendered until resolution of My Claim:

____ 1. I now assign, without any right to later revoke, a part of any proceeds from My Claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by this Clinic. I am **NOT** assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim, I understand and permit HCC to pursue payment from any other source but me personally, including medical payments coverage in an automobile liability policy.

____ 2. This Assignment, and related documents which I have signed in connection with it, states the entire agreement and my complete understanding regarding HCC's fees. I have not relied on any statements by HCC or the Doctor or other information before making this Assignment. I understand that I remain responsible for any HCC fees not paid out of My Claim.

____ 3. I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered.

____ 4. I understand that this is an express contract to pay for the services rendered by HCC. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.

____ 5. I understand that HCC is not obligated to bill my health insurance company for treatment related to My Claim and that my health insurance company will deny care for My Claim when another party, or their insurance, is responsible.

____ 6. NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.

____ 7. I understand this agreement authorizes representatives of HCC to contact and discuss my case with any interested parties involved in My Claim.

____ 8. I understand that HCC will delay billing me personally for My Claim, but HCC has the discretion to call my medical bills due (especially regarding lack of communication or cooperation by me and/or my attorney). Billing may be made to my health insurance company or to me personally. If the filing limit has passed for my health insurance company, I acknowledge that I am responsible for my medical bills in full.

____ 9. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and venue shall lie in Lucas County, in which HCC is located, unless required by applicable law to lie in a different county in which I reside. If any portion of this agreement is found to be invalid, the remainder of the agreement remains in effect.

____ 10. I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.

____ 11. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

______________________________ ______________________________
Patient Signature Patient's Name

________________ ______________________________ ______________________
Date Signature of Parent or Legal Guardian Staff Witness