Motor Vehicle Accident Information

Name: _____ Sex: M / F Height: ____'___ Weight: _____

Dominant Hand R / L Date of birth: _____/_____/_____Occupation:_____

Physical Address:_____

Mailing Address: _____

Phone Number(s): _____/_____

Name of your medical doctor: _____ Last visit date: _____

List any medical conditions and/or medications: _____

Have you retained an attorney? □Yes □No Name_____ Phone _____

Please check any of these symptoms you have ever experienced:

O Chest Pains O High Blood Pressure O Stroke O Cancer O Infertility O Blood Clots
O Diabetes O Asthma O Heart Attack O Dizziness O Shortness of Breath

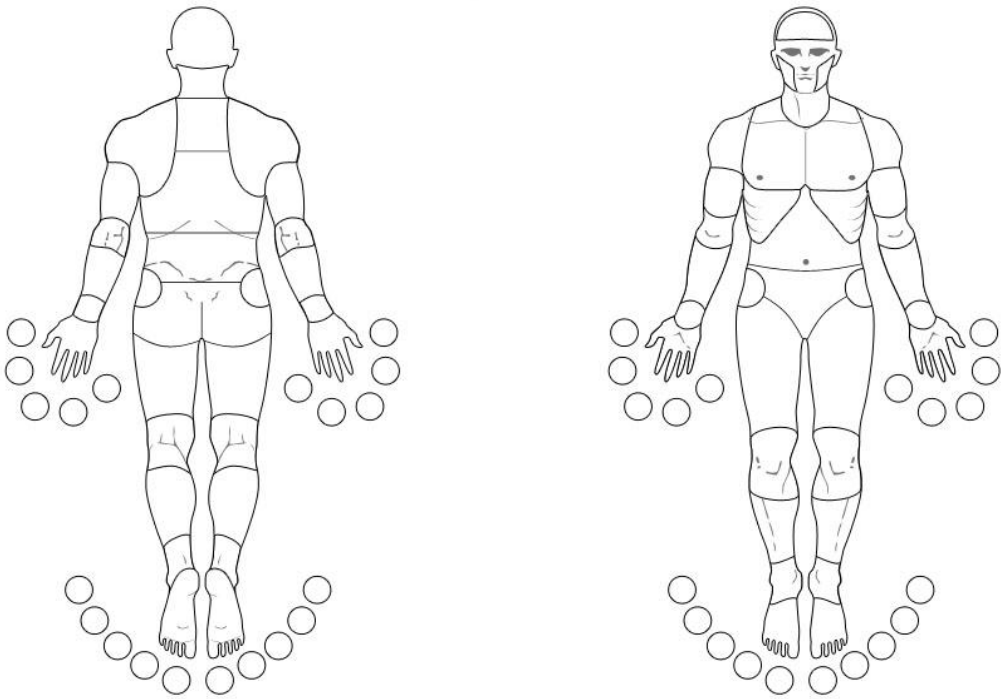
Please list all surgeries you have had:_____

_____

Initial Here: _____ Are you Pregnant? Y / N How many weeks?: _____ Date of last menstrual cycle: _____
Do you smoke? Y / N How long?: _____ How many per day?: _____Have you tested HIV positive? Y / N
Do you consume: alcohol (#_____ drinks per week) caffeinated drinks (#_____ drinks per day)
Would you say your health is: ____poor ____fair ____good ____excellent
Do you exercise? Y / N Type of exercise: _____ Hours per week: _____
Any significant family history of heart disease, cancer, stroke, Alzheimer's, diabetes, etc.? (list family member and condition):_____

_____

Please indicate any areas of pain on the drawing by placing a number from 1 through 10 on each location of discomfort.
1= Minimal Pain / 10 = Extreme Pain



General Information

Date of Accident:			
Location (circle one)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Please Circle:

Patient's Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / Motor Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH**)**	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information

Impact Information: Vehicle or Object

(Select one)	**Name Object :**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Pickup / Truck / Bus / SUV / Motor Cycle / Other:
	Size :	Mini / Sub Comp / Compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location (Circle)	Center Front / Front Right / Front Left / Passenger Side / Driver Side / Center Back / Back Right Back Left / Other (specify): _____	

During Impact Information:

Were you wearing your seat belt?	☐ Yes	☐ No	Were the brakes applied?	☐ Yes	☐ No
Was your Air Bag deployed?	☐ Yes	☐ No	Was your seat broken?	☐ Yes	☐ No
Did your Seat Back position change?	☐ Yes	☐ No			

Head Rest Position : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown during accident?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Right / Left / Unsure / Other:

Head Position and Movement During Accident(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact

Did any part of your body hit anything during the accident? If so, please describe:	Yes ☐ No ☐ If yes, explain:

Previous Injuries

Have you had any Previous Injuries or Accidents?	☐ No ☐ Yes, Specify:
Do you have any residual pain from Previous Injuries/Accidents?	☐ No ☐ Yes, Specify:

After Accident Information:

Immediately after the accident, did you experience any of these symptoms?	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐ Nauseas ☐ Light-headed ☐ Blurred vision ☐ Ringing/ Buzzing in Ears ☐/Other:
Describe any pain that started **immediately after the accident:**	_____

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear **R / L** ☐ Double Vision ☐ Other Specify:
Neck	☐ Pain in Neck **Type (circle)**: Sharp / Stabbing / Dull / Ache / Burning / Shooting / Throbbing **Location (circle):** Left / Right / Center / Bilateral ☐ Pain Tilting Head Up ☐ Pain Turning Left ☐ Pain Turning Right ☐ Pain Putting Neck Forward ☐ Pain Tilting Head Left ☐ Popping in Neck ☐ Pain Tilting Head Right ☐ Muscle Spasms ☐ Other Specify:
Shoulders	☐ Pain in Shoulder joint: **circle one**: **R / L** ☐ Tension in shoulder(s) ☐ Muscle Spasms in Shoulder(s) ☐ Pain across shoulder(s) ☐ Popping or clicking in shoulder(s) ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers **R / L** ☐ Numbness in Arm **R / L** ☐ Hands Cold **R / L** ☐ Wrist Pain **R / L** ☐ Loss of Grip Strength **R / L** ☐ Tingling in hands or fingers **R / L** ☐ Other Specify:
Chest	☐ Chest pain ☐ Pain Around Ribs **R / L** ☐ Shortness of Breath ☐ Breast Pain **R / L** ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Mid back pain **Type (circle)**: Sharp / Stabbing / Dull / Ache / Burning / Shooting / Throbbing **Location (circle):** Left / Right / Center / Bilateral ☐ Pain From front to back ☐ Muscle Spasms ☐ Pain in Kidney Area ☐ Pain in Ribs **R / L** ☐ Other Specify:
Lower Back	☐ Low Back Pain **Type (circle)**: Sharp / Stabbing / Dull / Ache / Burning / Shooting / Throbbing **Location (circle):** Left / Right / Center / Bilateral ☐ Muscle Spasms ☐ Popping in Lower Back ☐ Other Specify:
Hips, Legs & Feet	☐ Buttock pain **R / L** ☐ Tingling or numbness in Leg **R / L** ☐ Pain down Leg **R / L** ☐ Hip Joint pain **R / L** ☐ Feet feel cold **R / L** ☐ Swollen Feet **R / L** ☐ Numbness in Toes **R / L** ☐ Knee pain **R / L** ☐ Ankle pain **R / L** ☐ Leg cramps **R / L** ☐ Cramps in Feet **R / L** ☐ Other Specify:
General Complaints **since the accident**:	☐ Nervousness ☐ Fatigue ☐ Cramping ☐ Irritable ☐ Depressed Loss of weight :[__]lbs ☐ Generally Feel Rundown ☐ Irregularity Gain weight : [___] lbs ☐ Difficulty Urinating ☐ Night Urination Loss of Sleep :[___] hrs per night Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes ☐ No	When? Next day / At time of Accident / Later that Day / Days Later:_____ (Specify)	
Transported	Drove Self / Ambulance / Someone drove you		
Went To	Orthopedic / Chiropractor / Neurologist / Family Doctor / ER / Other:(Specify)		
Were you Admitted to the Hospital?	☐ Yes ☐ No #_____ Days Spent in Hospital		
Tests:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)		
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)		

Patient Name_____ Date_____Activities of Daily Living

Instructions: Within each section, please indicate how your current symptoms are affecting your daily living by selecting one of the options.

Self Care/Hygiene

[__] I can provide for myself on most of my personal care.
[__] I can provide for myself, but it creates extra pain.
[__] I can provide for myself, I am slow, careful, and it is painful.
[__] I manage most of my personal care, but it requires some help.
[__] In most accommodations of my daily care, I require extra help.
[__] It is too difficult to care for myself, I stay in bed and do not perform these tasks.

Communication

[__] I can communicate in a normal fashion.
[__] I can communicate, but it causes some pain.
[__] My communication abilities are normal, but always painful.
[__] My communication abilities are restricted by pain.
[__] Pain seriously limits my communication except for emergencies.
[__] Pain prevents communication abilities completely.

Normal Living - Sitting

[__] I am able to assume a sitting position for an indefinite period of time without pain.
[__] I can sit down for an indefinite period of time, but it causes some pain.
[__] I am restricted to one hour of sitting due to pain.
[__] Due to pain, I am only able to sit for 30 minutes.
[__] Pain restricts sitting for longer than 10 minutes.

Normal Living - Standing

[__] I am able to stand as long as I like without pain.
[__] I am able to stand for an indefinite period of time, but it causes pain.
[__] I am restricted to one hour of standing due to pain.
[__] Due to pain, I am only able to stand for 30 minutes.
[__] Pain restricts standing for longer than 10 minutes.
[__] I am unable to stand due to pain.

Normal Living - Lifting

[__] I am able to lift heavy objects without pain.
[__] I am able to lift heavy objects, but it causes some pain.
[__] I am unable to lift heavy objects off the floor. However, I can manage if they are at table height.
[__] Due to pain, I am not able to lift heavy objects. However, light to medium weight objects are manageable.
[__] Pain restricts lifting only very lightweight objects.

Ambulation

[__] I am able to walk any distance without pain restrictions.
[__] I am limited to walk one mile due to pain restrictions.
[__] I am limited to ½ mile of walking due to pain.
[__] Due to pain, I am restricted to walking less than ¼ mile.
[__] I require the use of crutches or a cane to assist walking.
[__] I remain in bed most of the time due to pain.

Pain Frequency

[__] I have INTERMITTENT symptoms occurring less than 25% of my wake time.
[__] I experience OCCASIONAL symptoms between 25% and 50% of my awake time.
[__] Pain is FREQUENT, and occurs between 50% and 75% of my awake time.
[__] I have CONSTANT pain occurring between 75% and 100% of my awake time.

Travel
[__] I am able to travel without pain restrictions.
[__] I am able to travel almost anywhere, but it causes pain.
[__] I can manage 2 hours of travel, but pain is present and severe.
[__] Due to pain, I am limited to less than an hour of travel time.
[__] Only short, urgent trips are possible due to pain limitations.
[__] I am restricted in travel due to pain, other than emergencies of short distances (hospital, doctor visit).

Non Specialized Hand Activities
[__] I can grasp in a normal fashion.
[__] I can utilize grip and tactile discrimination, but there is some pain.
[__] My grasp and grip capabilities are normal, but always painful.
[__] Grasping, grip strength can tactile sensations are restricted by pain.
[__] prevents grip strength, grasping and tactile discrimination completely.
[__] Pain prevents grip strength, grasping and tactile discrimination completely.

Sexual Function
[__] I am able to engage in normal sexual activities without pain.
[__] I am able to participate sexually, but it creates some pain.
[__] I engage normally in sexual activities, but it is very painful.
[__] I am restricted in sexual activities due to pain.
[__] Pain has created a near absent sex life.
[__] Due to pain, I abstain from any sexual activities.

Sleep
[__] I sleep well in a normal fashion.
[__] I sleep well at night, as long as I use sleeping pills.
[__] I fail to accomplish more than 6 hours of sleep.
[__] I fail to accomplish more than 4 hours of sleep.
[__] I fail to accomplish more than 2 hours of sleep.
[__] Pain prevents sleep.

Social & Recreational Activities
[__] I am enjoying a normal, active social life without pain restrictions.
[__] The presence of pain affects only the more energetic activities of my social life (bowling, golfing, sports, etc.).
[__] I participate in a normal social life, but pain is increased during most activities.
[__] Pain restricts all of my social activities; therefore, I do not go as often.
[__] I am restricted to social activities at home due to pain.
[__] Due to pain, I do not participate in any social activities.

The Effects Of Medication
[__] I am able to tolerate pain; therefore, I do not use any pain medication.
[__] I use pain medication and experience complete relief from pain.
[__] I use pain medication and experience moderate relief from pain.
[__] Pain medication offers only very little relief from pain.
[__] Pain medication fails to offer relief; therefore, I no longer take them.

Pain Intensity
[__] My pain is MINIMAL and tolerated, it is annoying, but does not limit my physical performance.
[__] Pain is SLIGHT and tolerated; it causes some limitations on my physical performance.
[__] I experience MODERATE pain, which causes a significant limitation on my physical performance of activities.
[__] I experience SEVERE pain, which reduces my capability to perform any activity.

NORTH GEORGIA SPINAL CARE
650 Henderson Drive, Suite 109 Cartersville, GA 30120
(770) 387-2265

DOCTOR'S LIEN CONTRACT

Patient Name:_____

Physical Address: _____

_____

Lien Details: I understand that North Georgia Spinal Care is withholding partial or full immediate payment or collection efforts of my balance as a courtesy to me given that the treatment which I am receiving arises out of a claim for which insurance coverage exists, either through my own insurance company or the insurance company of a third party. **I UNDERSTAND THAT I AM PERSONALLY, DIRECTLY, AND FULLY RESPONSIBLE TO THE SAID DOCTOR FOR ALL MEDICAL BILLS** submitted by him for services rendered to me and this agreement is made solely for the said doctor's additional protection and in consideration for this awaiting payment. In the event that I am not able to make full payment for the services I received in this office within 3 months after the date that treatment in this office for my injuries has ceased, I will be required to begin a repayment program of a minimum of $25 per week, until I can repay the amount in full. I recognize that any payments that I make before my case is settled will be deducted from my final balance.

Attorney clause: In the case that I retain an attorney, I hereby authorize and direct my attorney to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. The doctor does not routinely accept percentages of settlement. The doctor will be paid in full or 100% of any outstanding bill after treatment is completed. Additionally, I authorize and direct my attorney to furnish said doctor with a final, signed copy of my settlement statement if a situation arises where the doctor agrees to a compromise on the final charges.

Authorization to release information: Further, I hereby authorize the above doctor's office to furnish my attorney and any involved insurance companies with a full report of his examination, diagnosis, treatment, prognosis, bills, claims, etc… of myself in regard to the accident in which I was involved.

Insurance Claims: I, _____ direct _____ to pay directly to North Georgia Spinal Care, LLC such sums as may be due and owing for chiropractic or medical services rendered me by reason of the accident relating to claim # _____.

Payments: If benefits are paid directly to you the patient, payment for your full bill will be expected promptly after your settlement is reached. Any unpaid balance over 30 days post settlement will be transferred to our collections agency. **If we refer your account to a collection agency, you agree to pay your balance in full in addition of up to 66.67% in collection fees.** The insurance company will make the final determination of your eligibility and amount of the settlement. If you disagree with any verification or payment on your behalf, it will be your responsibility to pay your account balance in full. Any discrepancies will be handled between you and your insurance company.

Returned Checks: There will be a $**30.00** fee assessed for all returned checks.

Details of individual agreement: _____

_____

I have read and understand the financial policy and agree to all terms and conditions stated herein.

_____ _____ _____

Patient or Legal Guardian Signature Date Witness Signature

INFORMED CONSENT TO CHIROPRACTIC TREATMENT
We would like to inform you about the possible risks of receiving or refusing chiropractic care.

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor 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. I also use some physical therapy techniques in my practice.

Analysis / Examination / Treatment
As part of the analysis, examination, and treatment, you are consenting to procedures including, but not limited to: spinal manipulative therapy (an adjustment), electrical muscle stimulation, hot or cold therapy, mechanical traction, therapeutic exercises, x-rays, range of motion testing, palpation, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, and vital signs.

The material risks inherent in chiropractic treatment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. Complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. 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. I will make every reasonable effort during the examination to screen you for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bones which I check for during the taking of your history and during examination and X-ray. There are reported cases of stroke associated with visits to medical doctors and doctors of chiropractic. Research and scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and doctors of chiropractic when they are in the early stages of a stroke. In essence, there is a stroke already in progress. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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, hospitalization, or surgery. If you choose 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 of 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.

PLEASE SIGN ONLY AFTER 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 had the opportunity to discuss any questions or concerns with Rob Buchkowski, D.C., and have had my questions answered to my satisfaction. I understand that results are not guaranteed. 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.

Patient or Legal Guardian signature _____Date _____

Patient Name (please print) _____Witness:_____

- **PATIENT NOTIFICATION OF ISSUES RELATING TO PRIVACY**

Per Federal HIPPA (Health Insurance Portability and Accountability Act) Privacy Rules *April, 2001*

With your consent, North Georgia Spinal Care may use and disclose protected health information (PHI) about you to carry out treatment, payment, insurance and health care operations.

Our Examination and Treatment rooms are private with walls that are 8 feet high, or reach the ceiling. Treatment rooms have doors; however they may remain open. Your treatment may also be performed in an open room with several therapy tables which may be in use by other patients.

On the day of your visit, your Patient Treatment file may be placed in insecure locations where your name is exposed (such as in a wall bin inside the Treatment Room).

We may disclose PHI about you to (1) our doctors, technicians, massage therapists, and staff members. (2) to people outside our practice who may be involved in your health care, such as other doctors providing services that are part of your care. (3) to a family member or friend who is involved in your health care or someone who helps pay for your care. (4) in a credit card dispute of charges, we may need to supply information that proves that the charges were appropriate for the care provided and that the care was in fact provided to the patient. (5) If you are involved in a lawsuit or similar proceeding, we may disclose your health information in response to a court or administrative order, in response to a subpoena, discovery requests, requests from insurance adjusters or for another lawful process by someone involved in the dispute. You have the right to request a list of persons who have access to your PHI. Make this request in writing to the office manager.

North Georgia Spinal Care may call your home or office and leave a message in reference to any items that assist the practice in carrying out health care operations such as appointment reminders and insurance items. North Georgia Spinal Care may mail to your home or office any items that assist the practice in carrying out health care operations such as appointment reminders, patient statements, promotions, postcards, etc. You have the right to request in writing that communications be restricted in a certain way (example: only call at work, never call cell phone, mail items to a different address) *We are not required to agree to your request, but if we do, we are bound by our written agreement.*

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment, and/or health care operations*. We are not required to agree to your requested restrictions, but if we do, we are bound by our written agreement with you.*

You have the right to: (1) inspect and obtain a copy of your health information. Submit your request for copies or inspection in writing. There is a fee associated with copying, printing, or mailing information. The fee is an administrative fee of $25, as well as a copying fee per single-sided page and the actual cost for certified mailing of the records. Requests will be responded to within 30 days. We are not always able to send or receive faxes. US mail is our primary and preferred method for sending and receiving information pertaining to health records. (2) You may request us, in writing, to amend your health information if you believe it is incorrect or incomplete. Requests may be denied with a written response and reasons.

If you believe your privacy rights have been violated, you may file a complaint with the practice, (Dr. Robin Buchkowski, DC, or the office manager) (770)387-2265 or with the Department of Health and Human Services. All complaints must be submitted in writing to insure clear communication.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. Your signature also provides your agreement to receive treatment in the clinic including the privacy issues outlined above. This consent may be revoked in writing to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may be forced to decline to provide treatment for you.

Signature of Patient or Legal Guardian_____ Date_____

Patient's Name (printed)_____