Confidential Patient Information

First Name:_____ Last Name:_____ DOB:_____

Phone:_____ Email:_____ SSN:_____

Gender: M☐/ F☐/ Other☐ Handedness: R☐/ L☐ /A☐ Referred by:_____

Address:_____ Apt#_____ City:_____ State:_____ Zip:_____

Employer:_____ Occupation:_____

Work Address:_____ City:_____

State:_____ Zip:_____ Work Phone:_____ Ext:_____

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Spouse:_____

Emergency Contact:_____ Phone:_____

Claim Information

Cause: Auto Accident☐ Personal Injury☐ Work Injury☐ Sports Injury☐ Other:_____

Type of Claim: Auto Accident☐ Personal Injury☐ Work Injury☐ Sports Injury☐ Other:_____

Insurance Name:_____ Claim#_____

Address:_____ City:_____ State:_____ Zip:_____

Adjuster:_____ Phone:_____ Fax:_____

Group Health Insurance

Relationship to the insured: Self☐ Spouse☐ Child☐ Other:_____

Insured's Employer (Same as Above☐) Other:_____ Insured's SS# (Same as Above☐)

Other SS#_____ Insured's DOB: (Same as Above☐) Other DOB:_____

Primary Insurance Co. _____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____ Ext:_____

Secondary Insurance Co. _____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____ Ext:_____

Attorney Information

Attorney Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____ Ext:_____

Authorizations:

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to either myself or to the party who accepts assignment. Additionally, I hereby authorize release of any medical information to any third party as I deem necessary for my medical benefit.

B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe to this office by my attorney, out of the proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and/or services rendered.

C. I Understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection form the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.

D. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Signature:_____ Date:_____

Incident & Injury Information

Date: _____ DOI: ___ _____

Name: _____ Age: ____ DOB: _____ Height: _____ Weight: _____

Handedness: R / L / A: Race: _____ Occupation: _____ FT / PT

Type of Injury: Auto ☐ Work ☐ Personal ☐ Sports ☐ Other: _____ Time: _____AM/PM

Were others involved? Yes ☐ No ☐ if yes Names: _____

Please describe the incident in your own words: _____

_____

_____

IF INJURY INVOLVED A VEHICLE (IF NOT SKIP TO HEAD POSITION)

Were you the driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Other ☐

Year and Model of your vehicle: _____ People in your vehicle: _____

What direction were you traveling? N / S / E / W Street: _____

Were you stopped? Yes / No. If no, your Est. speed: _____ Struck from the F / R / P / D

Year and model of other vehicle(s): _____

Direction of other vehicle(s): N / S / E / W Street: _____

Were they stopped? Yes / No. If no, their Est. speed: _____ Struck from the F / R / P / D

_____

Road Conditions? Wet ☐ Dry ☐ Visibility? Good ☐ Poor ☐ Wearing a seat belt? Yes ☐ No ☐

With shoulder harness? Yes ☐ No ☐ Were you aware of the impending collision? Yes ☐ No ☐

If yes, did you brace and how? _____ Did the air bags deploy? Yes ☐ No ☐

Were the police notified? Yes ☐ No ☐ If yes, was a report filed? Yes ☐ No ☐

HEAD POSITION

Your head position at injury? _____ Did you lose consciousness? Yes ☐ No ☐ If yes,

Please explain: _____

_____

Were you taken anywhere by ambulance or private party? Yes ☐ No ☐ If yes, please explain any testing, medications and/or treatment you received: _____

_____

_____

How did you feel immediately following the incident? _____

_____

How did you feel later that day? _____

_____

How did you feel the next day? _____

_____

How did you feel the following days? _____

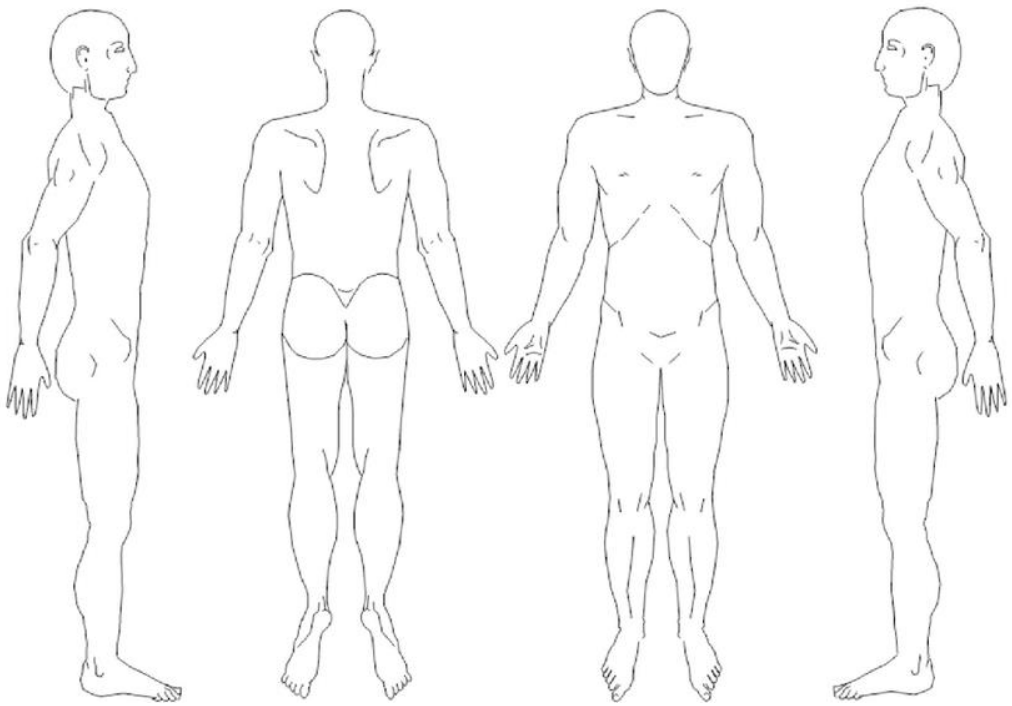
_____

Concussion & Whiplash Clinic, LLC • www.ConcussionPDX.com • Phone 503.512.5359 •
Fax 971-249-8767• 7100 SW Hampton St. Suite 121, Tigard, Oregon 97223

Incident & Injury Information

Name: _____ DOB: _____

Please mark all areas of pain on the diagrams below:



Please list your current health concerns related to your injuries in order of priority: _____

_____

_____

Did your injuries occur while performing your job duties? Yes ☐ No ☐ If yes, please explain:

_____

Has your condition impaired performing your job duties? Yes ☐ No ☐ If yes, please explain:

_____

Have you lost time from work as a result of your injuries? Yes ☐ No ☐ If yes, please explain:

_____

How do these conditions impair your daily activities? _____

_____

How do these conditions impair your social activities? _____

_____

What makes your condition better? _____

_____

What makes your condition worse? _____

_____

Anything else you would like to share? _____

_____

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Incident & Injury Information

Name: _____ DOB: _____

Did you have any health complaints prior to your injuries? Yes ☐ No ☐ If yes, please explain:

_____

_____

Have you ever had your current injuries before this incident? Yes ☐ No ☐ If yes, please explain:

_____

_____

*If you have experienced any of the following conditions in the past, please mark **(P)** on the line provided.*
*If you are currently experiencing any of the following conditions, please mark **(C)** on the line provided.*

____Heart Attack
____Stroke
____High BP
____Diabetes
____Cancer
____Arthritis
____Kidney Stones
____Gall bladder
____Prostate Problems
____Nausea/Vomiting
____Dizziness
____Headache
____Memory Loss
____Fainting
____Hearing Loss
____Brain Fog

____Communication Challenges
____Ringing in Ears
____Asthma
____Diarrhea
____Constipation
____Trouble Swallowing
____Indigestion/Reflux
____Abdominal Pain
____Difficulty W/ Urination
____Blood in Urine
____Blood in Stool
____Gout
____Muscle Pain
____Joint Replacement
____Joint Pain
____Unexplained Fatigue

____Unexplained Weight Loss
____Unexplained Weight Gain
____Recent Fever/Sweats
____Chest Pain/Discomfort
____Palpitations
____Shortness of Breath
____Anxiety/Stress
____Sleep Problems
____Coughing/Wheezing
____Change in Vision
____Glaucoma
____Cold/Heat Intolerance
____Increased Thirst
____Light Intolerance
____Sensitivity to Noise
____Memory Challenges
____Over/Under Emotional

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patients Signature: _____ Date: _____

Guardians Signature: _____ Date: _____

Incident & Injury Information

Name: _____ DOB: _____

Place a check on the line in the first (1st) column if you had any of these symptoms before the collision.
Place a check on the line in the second (2nd) column if you had any of these symptoms after the collision.
Place a check on the line in the third (3rd) column if you are experiencing any of these symptoms today.
Please leave the last column blank (for office use only)

Difficulty with Thinking/Remembering	Before DOI	After DOI	Today	Today 0/10
Thinking Clearly	____	____	____	_____
Concentration, focus, and/or organization	____	____	____	_____
Memory	____	____	____	_____
Reading/Comprehension	____	____	____	_____
Loss of insight and/or poor judgment	____	____	____	_____

Difficulty with Sleep	Before DOI	After DOI	Today	Today 0/10
Sleeping more than usual/less than usual	____	____	____	_____
Falling asleep/Staying asleep	____	____	____	_____
Mental and/or Physical Fatigue	____	____	____	_____

Physical	Before DOI	After DOI	Today	Today 0/10
Headache	____	____	____	_____
Fuzzy, blurry and/or double vision	____	____	____	_____
Nausea and/or vomiting	____	____	____	_____
Dizziness and/or light-headed	____	____	____	_____
Balance problems / feelings of falling and/or spinning	____	____	____	_____
Difficulty speaking and/or writing	____	____	____	_____
Decrease or loss of smell/taste	____	____	____	_____
Sensitivity to noise, and/or light	____	____	____	_____

Emotion, Mood and Affect	Before DOI	After DOI	Today	Today 0/10
Feeling more emotional and/or emotionally fragile	____	____	____	_____
Feeling nervous/restless and/or anxious	____	____	____	_____
Feeling irritable/frustrated and/or impatient/angry	____	____	____	_____
Feeling apathetic and/or without motivation	____	____	____	_____
Feeling depressed, sad and/or tearful	____	____	____	_____
Personality changes	____	____	____	_____
Neglecting personal hygiene	____	____	____	_____
Socially inappropriate behavior	____	____	____	_____
Unusual sexual behavior and/or loss of libido	____	____	____	_____

Incident & Injury Information

Name: _____ DOB: _____

Place a check on the line in the first (1st) column if you had any of these symptoms before the collision.
Place a check on the line in the second (2nd) column if you had any of these symptoms after the collision.
Place a check on the line in the third (3rd) column if you are experiencing any of these symptoms today.
Please leave the last column blank (for office use only)

Head, Face, and Neck Pain:	Before DOI	After DOI	Today	Today 0/10
Headache – Right / Left	____	____	____	_____
Face – Right / Left	____	____	____	_____
Upper Neck – Right / Left / Midline	____	____	____	_____
Lower Neck – Right / Left / Midline	____	____	____	_____

Back Pain:	Before DOI	After DOI	Today	Today 0/10
Upper Back – Right / Left / Midline	____	____	____	_____
Middle Back – Right / Left / Midline	____	____	____	_____
Lower Back – Right / Left / Midline	____	____	____	_____
Pelvis – Right / Left / Midline	____	____	____	_____

Upper Body Pain:	Before DOI	After DOI	Today	Today 0/10
Shoulders - Right / Left / Front / Back	____	____	____	_____
Arms - Right / Left	____	____	____	_____
Hands - Right / Left	____	____	____	_____
Fingers - Right / Left	____	____	____	_____

Lower Body Pain:	Before DOI	After DOI	Today	Today 0/10
Hips - Right / Left	____	____	____	_____
Thighs - Right / Left	____	____	____	_____
Legs - Right / Left	____	____	____	_____
Feet - Right / Left	____	____	____	_____

Are you experiencing any other difficulties?

1. _____
2. _____

Thank you for taking the time to fill out this form as completely as possible. Successful healthcare preventative medicine is only possible when the practitioner has a complete understanding of the patients physical, mental, and emotional state.