SHEPPARD
Spine and Sports Clinic

MOTOR VEHICLE ACCIDENT PAPERWORK

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PERSONAL INJURY QUESTIONNAIRE

NAME PHONE #

ADDRESS CITY STATE ZIP

AGE BIRTHDATE SEX SSN

EMPLOYER'S NAME EMPLOYER'S ADDRESS

YOUR INSURANCE CO. POLICY # AGENT

NAME ON POLICY (IF OTHER THAN SELF) POLICY #

RESPONSIBLE PARTY'S NAME

ADDRESS CITY STATE ZIP

POLICY HOLDER'S NAME POLICY #

ATTORNEY PHONE #

ADDRESS CITY STATE ZIP

WERE THERE ANY WITNESSES? ☐ YES ☐ NO NAME(S)

NATURE OF ACCIDENT

1. DATE OF ACCIDENT TIME OF DAY

2. WERE YOU ☐ DRIVER ☐ PASSENGER ☐ FRONT SEAT ☐ BACK SEAT

3. NUMBER OF PEOPLE IN VEHICLE? WERE YOU WEARING SEATBELTS? ☐ YES ☐ NO

4. WHAT DIRECTION WERE YOU HEADED? ☐ NORTH ☐ EAST ☐ SOUTH ☐ WEST

ON (NAME OF STREET)

5. WHAT DIRECTION WAS OTHER VEHICLE HEADED? ☐ NORTH ☐ EAST ☐ SOUTH ☐ WEST

ON (NAME OF STREET)

6. WERE YOU STRUCK FROM ☐ BEHIND ☐ FRONT ☐ LEFT SIDE ☐ RIGHT SIDE

7. APPROXIMATE SPEED OF YOUR CAR OTHER CAR

8. WERE YOU KNOCKED UNCONSCIOUS ☐ YES ☐ NO IF YES, FOR HOW LONG?

9. WERE POLICE NOTIFIED ☐ YES ☐ NO

10. IN YOUR OWN WORDS, PLEASE DESCRIBE ACCIDENT:

11. DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE IN DETAIL:

12. PLEASE DESCRIBE HOW YOU FELT:

A. DURING THE ACCIDENT:

B. IMMEDIATELY AFTER THE ACCIDENT:

C. LATER THAT DAY:

D. THE NEXT DAY:

13. WHAT ARE YOUR PRESENT COMPLAINS AND SYMPTOMS?

14. DO YOU HAVE ANY CONGENITAL (FROM BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE:

15. DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE:

16. HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE, INCLUDING DATE(S) AND TYPE(S) OF ACCIDENTS, AS WELL AS INJURY(IES) RECEIVED:

17. WHERE WERE YOU TAKEN AFTER THE ACCIDENT?

18. HAVE YOU BEEN TREATED BY ANOTHER DOCTOR SINCE THE ACCIDENT? ☐ YES ☐ NO

IF YES, PLEASE LIST DOCTOR'S NAME AND ADDRESS

WHAT TYPE OF TREATMENT DID YOU RECEIVE?

19. SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS: ☐ IMPROVING ☐ GETTING WORSE ☐ THE SAME

20. CHECK SYMPTOMS YOU'VE NOTICED SINCE ACCIDENT

☐ HEADACHE	☐ IRRITABILITY	☐ NUMBNESS IN TOES	☐ FACE FLUSHED	☐ FEET COLD
☐ NECK PAIN	☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ BUZZING IN EARS	☐ HANDS COLD
☐ NECK STIFF	☐ DIZZINESS	☐ FATIGUE	☐ LOSS OF BALANCE	☐ STOMACH UPSET
☐ SLEEPING PROBLEMS	☐ HEAD SEEMS TOO HEAVY	☐ DEPRESSION	☐ FAINTING	☐ CONSTIPATION
☐ BACK PAIN	☐ PINS & NEEDLES IN ARMS	☐ LIGHTS BOTHER EYES	☐ LOSS OF SMELL	☐ COLD SWEATS
☐ NERVOUSNESS	☐ PINS & NEEDLES IN LEGS	☐ LOSS OF MEMORY	☐ LOSS OF TASTE	☐ FEVER
☐ TENSION	☐ NUMBNESS IN FINGERS	☐ EARS RING	☐ DIARRHEA	☐ _____

21. HAVE YOU LOST TIME FROM WORK AS A RESULT OF THE ACCIDENT? ☐ YES ☐ NO IF YES, COMPLETE BELOW

A. LAST DAY WORKED:

B. TYPE OF EMPLOYMENT:

C. PRESENT SALARY:

D. ARE YOU BEING COMPENSATED FOR TIME LOST AT WORK? ☐ YES ☐ NO

IF YES, PLEASE STATE THE TYPE OF COMPENSATION YOU ARE RECEIVING

22. DID YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE IN DETAIL:

23. OTHER PERTINENT INFORMATION:

PATIENT SIGNATURE

DATE

NECK DISABILITY INDEX

PATIENT NAME _____ **DATE** _____

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

1. PAIN INTENSITY:
- ○ I have no pain at the moment
- ○ The pain is very mild at the moment
- ○ The pain is moderate at the moment
- ○ The pain is fairly severe at the moment
- ○ The pain is very severe at the moment
- ○ The pain is the worst imaginable at the moment

2. PERSONAL CARE:
- ○ can look after myself normally without causing extra pain
- ○ I can look after myself normally but it causes extra pain
- ○ It is painful to look after myself and I am slow and careful
- ○ I need some help but can manage most of my personal care
- ○ I need help every day in most aspects of self care
- ○ I do not get dressed, I wash with difficulty and stay in bed

3. LIFTING:
- ○ I can lift heavy weights without extra pain
- ○ I can lift heavy weights but it gives extra pain
- ○ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ○ I can only lift very light weights
- ○ I cannot lift or carry anything

4. READING:
- ○ I can read as much as I want to with no pain in my neck
- ○ I can read as much as I want to with slight pain in my neck
- ○ I can read as much as I want with moderate pain in my neck
- ○ I can't read as much as I want because of moderate pain in my neck
- ○ I can hardly read at all because of severe pain in my neck
- ○ I cannot read at all

5. HEADACHES:
- ○ I have no headaches at all
- ○ I have slight headaches, which come infrequently
- ○ I have moderate headaches, which come infrequently
- ○ I have moderate headaches, which come frequently
- ○ I have severe headaches, which come frequently
- ○ I have headaches almost all the time

6. CONCENTRATION:
- ○ I can concentrate fully when I want to with no difficulty
- ○ I can concentrate fully when I want to with slight difficulty
- ○ I have a fair degree of difficulty in concentrating when I want to
- ○ I have a lot of difficulty in concentrating when I want to
- ○ I have a great deal of difficulty in concentrating when I want to
- ○ I cannot concentrate at all

7. WORK:
- ○ I can do as much work as I want to
- ○ I can only do my usual work, but no more
- ○ I can do most of my usual work, but no more
- ○ I cannot do my usual work
- ○ I can hardly do any work at all
- ○ I can't do any work at all

8. DRIVING:
- ○ I can drive my car without any neck pain
- ○ I can drive my car as long as I want with slight pain in my neck
- ○ I can drive my car as long as I want with moderate pain in my neck
- ○ I can't drive my car as long as I want because of moderate pain in my neck
- ○ I can hardly drive at all because of severe pain in my neck
- ○ I can't drive my car at all

9. SLEEPING:
- ○ I have no trouble sleeping
- ○ My sleep is slightly disturbed (less than 1 hr sleepless)
- ○ My sleep is mildly disturbed (1-2 hrs sleepless)
- ○ My sleep is moderately disturbed (2-3 hrs sleepless)
- ○ My sleep is greatly disturbed (3-5 hrs sleepless)
- ○ My sleep is completely disturbed (5-7 hrs sleepless

10. RECREATION:
- ○ I am able to engage in all my recreation activities with no neck pain at all
- ○ I am able to engage in all my recreation activities, with some pain in my neck
- ○ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- ○ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ○ I can hardly do any recreation activities because of pain in my neck
- ○ I can't do any recreation activities at all

SCORE ☐

BACK INDEX

PATIENT NAME _____ **DATE** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY:
- ○ The pain comes and goes and is very mild.
- ○ The pain is mild and does not vary much.
- ○ The pain comes and goes and is moderate.
- ○ The pain is moderate and does not vary much.
- ○ The pain comes and goes and is very severe.
- ○ The pain is very severe and does not vary much.

SLEEPING:
- ○ I get no pain in bed.
- ○ I get pain in bed but it does not prevent me from sleeping well.
- ○ Because of pain my normal sleep is reduced by less than 25%.
- ○ Because of pain my normal sleep is reduced by less than 50%.
- ○ Because of pain my normal sleep is reduced by less than 75%.
- ○ Pain prevents me from sleeping at all.

SITTING:
- ○ I can sit in any chair as long as I like.
- ○ I can only sit in my favorite chair as long as I like.
- ○ Pain prevents me from sitting more than 1 hour.
- ○ Pain prevents me from sitting more than 1/2 hour.
- ○ Pain prevents me from sitting more than 10 minutes.
- ○ I avoid sitting because it increases pain immediately.

STANDING:
- ○ I can stand as long as I want without pain.
- ○ I have some pain while standing but it does not increase with time.
- ○ I cannot stand for longer than 1 hour without increasing pain.
- ○ I cannot stand for longer than 1/2 hour without increasing pain.
- ○ I cannot stand for longer than 10 minutes without increasing pain.
- ○ I avoid standing because it increases pain immediately.

LIFTING:
- ○ I can lift heavy weights without extra pain.
- ○ I can lift heavy weights but it causes extra pain.
- ○ Pain prevents me from lifting heavy weights off the floor.
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ○ I can only lift very light weights.

PERSONAL CARE:
- ○ I do not have to change my way of washing or dressing in order to avoid pain.
- ○ I do not normally change my way of washing or dressing even though it causes some pain.
- ○ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ○ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ○ Because of the pain I am unable to do some washing and dressing without help.
- ○ Because of the pain I am unable to do any washing and dressing without help.

TRAVELING:
- ○ I get no pain while traveling.
- ○ I get some pain while traveling but none of my usual forms of travel make it worse.
- ○ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ○ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ○ Pain restricts all forms of travel except that done while lying down.
- ○ Pain restricts all forms of travel.

WALKING:
- ○ I have no pain while walking.
- ○ I have some pain while walking but it doesn't increase with distance.
- ○ I cannot walk more than 1 mile without increasing pain.
- ○ I cannot walk more than 1/2 mile without increasing pain.
- ○ I cannot walk more than 1/4 mile without increasing pain.
- ○ I cannot walk at all without increasing pain.

SOCIAL LIFE:
- ○ My social life is normal and gives me no extra pain.
- ○ My social life is normal but increases the degree of pain.
- ○ Pain has no significant affect on my social life apart from limiting my more energetic interests.
- ○ Pain has restricted my social life and I do not go out very often.
- ○ Pain has restricted my social life to my home.
- ○ I have hardly any social life because of the pain.

CHANGING DEGREE OF PAIN:
- ○ My pain is rapidly getting better.
- ○ My pain fluctuates but overall is definitely getting better.
- ○ My pain seems to be getting better but improvement is slow.
- ○ My pain is neither getting better or worse.
- ○ My pain is gradually worsening.
- ○ My pain is rapidly worsening.

INDEX SCORE = [SUM OF ALL STATEMENTS SELECTED / (# OF SECTIONS WITH A STATEMENT SELECTED X 5)] X 100 **SCORE** ☐

APPOINTMENT & FINANCIAL POLICIES

With our computer sign in system, each patient is assigned a pin number. Which phone number (including area code) would you like to use as your pin number?

This software also allows us to automatically confirm patient appointments using text or email notifications. Please choose which method you would prefer and file out the appropriate information. Please choose only one option:

1. **TEXT NOTIFICATIONS:**

   PHONE NUMBER: _____

   PHONE CARRIER: _____

2. **EMAIL NOTIFICATIONS:**

   EMAIL ADDRESS: _____

We would like to explain our financial policy. As customary with professional services, payment is due at the time of service. All services rendered are charged directly to you and you are personally responsible for payment. So that we have sufficient time for all our patients, we appreciate a 24-hour cancellation notice for all scheduled appointments. Failure to give 24-hour notice may result in a $20.00 cancellation fee.

If you have any questions regarding financial matters, or are in need of payment arrangements, please feel free to consult with our staff. We are all here to make your chiropractic visits as effective and pleasant as possible.

PATIENT SIGNATURE _____ **DATE** _____

INFORMED CONSENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in California. This sis called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of you consultation, examination, x-ray taking, physical therapy application traction, massage therapy, exercise instruction, etc. occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

STROKE: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is missed or uncertain as to whether chiropractic adjustments are associated with stroke or not. The most recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this stroke ranges between 1 per every 400,000-3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Two other potential problems that are not quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury and spinal dural tear resulting in a leak of cerebral spinal fluid.

DISC HERNIATIONS: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. this includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction, these problems occur so rarely that there are no available statistics to quantify their incidence.

CAUDA EQUINA SYNDROME: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to urinate or to start a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so is only 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department.

SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their incidence.

RIB AND OTHER FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patient that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their incidence.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. These problems occur so rarely that there are no available statistics to quantify their incidence. Never put a home ice pack directly on the skin, always have an insulating towel between.

SORENESS: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any healthcare delivery system we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist you r situation.

If you have any question on the above, please ask your doctor. When you have a full understanding, please sign and date below.

PATIENT'S NAME PRINTED

DATE

PATIENT'S SIGNATURE

PARENT OR GUARDIAN SIGNATURE FOR MINOR

SHEPPARD SPINE AND SPORTS CLINIC'S PRIVACY POLICY—SHORT FORM

Safeguarding your health information is important to us. As providers of care, we have certain practices to help protect your health information. This summarizes some of those privacy practices that are used by Sheppard Spine and Sports Clinic. You are entitled to receive and review our full length legal notice of privacy practices that you may obtain at our office or by calling (858) 350-6290.

The Health Insurance Portability and Accountability Act of 1996, or HIPP A allows the use of certain health information for the following activities:

- **TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.**
- **PAYMENT: We may use or disclose your health information to obtain payment for services we provide to you.**
- **HEALTHCARE OPERATIONS: We may use or disclose your health information in connection with our healthcare operations or when permitted by HIPP A. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.**

If our use or disclosure is not for one of the activities described above and is not otherwise permitted under HIPP A, we will ask you to complete a written authorization before we use or release your health information. When receiving services from us, you will also be able to decide whether we can discuss your health information with your family and friends.

Even if you have provided us with your authorization, you may withdraw that authorization, in writing, at any time to stop future disclosures of you health information.

HIPP A provides you with the following rights:
Restricting a use/disclosure, requesting confidential communications, inspecting and obtaining copies of your health information, requesting a change in your health information, requesting an accounting of disclosures of your health information, obtaining notice of our privacy polices.

If you believe that the privacy of your health information has been violated, you may contact us to discuss your concern or file a complaint at 858-350-6290 or 634 Stevens Ave. Solana Beach, CA 92075. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

By signing this form, you consent to our use and disclosure of your protected health information as indicated above and in the full length Notice of Privacy Practices. Please note that your personal information is not shared with third parties and use is restricted to procedures that are relevant to your care.

PATIENT SIGNATURE

DATE

MEDICAL PAYMENT POLICY INFORMATION

This is your auto insurance information, Not the other person's third party policy information.

YOUR INSURANCE CARRIER

ADJUSTER'S NAME **PHONE**

CLAIM # **DATE OF ACCIDENT**

FOR OFFICE USE

FINANCIAL AGREEMENT: AUTO ACCIDENT/PERSONAL INJURY

We would like to take a moment to familiarize you with the financial policy of our office, and how your medical bills will be handled.

If you are involved in an auto accident, your claims can be handled one of two ways:

1. **Your auto insurance will pay for your visits directly.**
   ***You must call your auto insurance company and open a "med pay claim"**
2. **You pay for each visit at the time of service and the other persons insurance will reimburse you when you settle with them at the end of your treatment.**
   ***The other persons insurance (3rd party) will NOT pay the doctor directly for your visits.**

Regardless of which option you choose, all services rendered by this office are charged directly to you, and you are ultimately responsible for payment. If you do not have MedPay on your auto policy or if another person's policy is going to cover your medical payments, then you will be responsible for payment at the time of service.

If you have any further questions, please feel free to ask any of the staff.

PATIENT SIGNATURE

DATE

CONSENT TO TREAT A MINOR

I, _____ , hereby authorize the doctors and staff of Sheppard Spine and Sports Clinic to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor child: _____

CHILD'S NAME

I certify that I have authority and responsibility to authorize treatment for the child.

INFORMED CONSENT:

I understand that chiropractic care is extremely safe: however I also understand that there are certain risks associated with any form of health care treatment. I accept that risk in order that he/she may receive treatment by the Doctors and Staff of Sheppard Spine and Sports Clinic.

_____

PARENT OR LEGAL GUARDIAN NAME PRINTED

_____

PARENT OR LEGAL GUARDIAN SIGNATURE

_____ _____

RELATIONSHIP TO PATIENT DATE