Plainfield Spine And Rehabilitation

Accidental Injury Information

Please Print

Basic Information about the Accident:

Date Accident Occurred or Started: ____/____/______

Time of Day when Accident Occurred or Started: ____________AM or PM

Describe how the Accident took place: ______________________________

____

____

____

____

____

Describe the condition or symptoms caused by the Accident: ______________________________

____

____

____

____

____

____

____

Work Accident Specific Information:

Complete only if this injury is work related:

- ☐ **Did the accident occur on the premises of the facility where you normally work? (i.e. local work address?)**
- ☐ **Did the accident occur during your normal working hours?**
- ☐ **Did you report the accident to your employer?**
- ☐ **Is your employer covered by Worker's Compensation Insurance under state law?**
- ☐ **Has your Employer prepared an initial written report?**
- ☐ **Does the Employer's Report describe the condition or symptoms you are experiencing?**
- ☐ **Has a claim number been issued for this accident?**
- ☐ **Have you received any written denial of liability from either your employer or Worker's Insurance Comp Payer?**

Print Name:______________________________ **D.O.B**____/____/____

Signed:______________________________ **Date**____/____/____

This was published and becomes effective October 2014

Plainfield Spine And Rehabilitation

Accidental Injury Information

Please Print

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year_________Make__________________ Model________________________

Damage to your car: ☐ Front ☐ Rear ☐ Driver side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage amount estimate: $______________ ☐ Minor ☐ Major ☐ Moderate ☐ Totaled

Other Automobile: N/A_____Year_________Make________________________ Model _____________________

Damage to other car: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage amount estimate (other car): ☐ Minor ☐ Major ☐ Totaled

Where did the accident happen?Street names:________________________City/State: ____________________

Was it: ☐ Controlled Intersection ☐ Uncontrolled Intersection ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Time of the day: ☐ Day ☐ Twilight ☐ Night

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy ☐ Clear

Street Surface ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _________________________

Type of Impact ☐ Rear End ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact ☐ Locked Tight ☐ Loosely Applied ☐ Foot Not on Brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle? _________________________Seat belt? ☐ Yes ☐ No

Shoulder Harness ☐ Yes ☐ No Headrest ☐ Yes ☐ No Headrest position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact, were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways

☐ Other _______________________________

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part_______________________________

What did it hit? ______________________________

Head trauma? ☐ Yes ☐ No Loss of consciousness? ☐ Yes ☐ No How long? _______________________

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital?____________________How long? __________________________

Taken by ambulance? ☐ Yes ☐ No X-rays taken? ☐ Yes ☐ No

X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other: ____________________________________

Medication given: ☐ Yes ☐ No RX: ____

Other instruction?_____________________________Follow-up: _________________________________

Was a police report filed? ☐ Yes ☐ No

How fast was your vehicle traveling? _______mph How fast was the other vehicle traveling? _______mph

Did the pain exist before the accident? ☐ No ☐ Yes If yes, explain: ______________________________

Patient Name____ **D.O.B.**_____/_____/_____

Signed____ **Date**_____/_____/_____

Patient Information

Name ______________________ Date ______________
Date of Birth ______________ Social Security # ______________
Sex: □ Male □ Female Height ____________ Weight ______________
Street Address ______________________________
City ______________ State ______________ Zip ____________
Home Phone ______________ Cell Phone ______________
Email address ______________________________
Occupation ______________________________
Employer ______________ Business Phone ______________
Are you: □ Married □ Single □ Domestic Partnership □ Divorced □ Separated
Spouses Name: ______________ # of Children ______________
Emergency Contact Name ______________ Relationship ______________
Contact Phone ______________________________
Name of Attorney ______________ Phone Number ______________

Medical History

Have you ever been treated by a Chiropractor? Y N

Family History

Check applicable	Father	Mother	Grandparent	Sibling	Other (Specify)
Anemia					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Psychological Disorder					
Asthma					
Hay fever, Hives					
Kidney Disease					
Glaucoma					
Tuberculosis					
Age at death					

Personal History

List hospitalizations or surgeries have you had with corresponding dates

____

Have you been diagnosed with any diseases or disorders and when?

____

Allergies?______________________________

Medications? ______________________________

Prior Fractures/ Broken Bones and where and when?______________________________

Please check any current symptoms below:

HEAD

_____headache
_____entire head
_____back of head
_____forehead
_____migraine
_____head feels heavy
_____loss of smell
_____loss of taste
_____loss of balance
_____loss of hearing
_____pain in ears
_____ringing in ears
_____light headed
_____sensitive to light
_____dizziness

MID BACK

_____pain
_____pain between shoulders
_____muscle spasms

LOW BACK

_____pain
_____pain increases with:
_____working
_____lifting
_____stooping
_____standing
_____sitting
_____bending
_____coughing
_____pinched nerve
_____slipped disc
_____feels "out of place"
_____arthritis
_____muscle spasms

NECK

_____pain
_____pain with movement
_____pinched nerve
_____feels "our of place"
_____stiffness
_____muscle spasms
_____grinding/popping
_____arthritis

SHOULDERS

_____pain in joints L or R
_____pain across shoulders
_____bursitis L or R
_____arthritis L or R
_____can't raise arms
_____above shoulder
_____above head
_____tension
_____pinched nerve
_____muscle spasm L or R

HIPS, LEGS & FEET

_____pain
_____in buttocks L or R
_____hip joint L or R
_____down leg L or R
_____leg cramps
_____pins & needles
_____numbness
_____leg L or R
_____foot L or R
_____toes L or R
_____cold feet
_____foot cramps L or R
_____swollen ankles L or R
_____swollen feel L or R
_____pain in toe joints

HANDS & ARMS

_____pain
_____upper arm L or R
_____forearm L or R
_____hand L or R
_____fingers L or R
_____pinched nerve
_____arm L or R
_____finger L or R
_____pins & needles in arm L or R
_____pins & needles in fingers L or R
_____fingers go "to sleep"
_____cold hands
_____swollen joints in fingers
_____sore joints in fingers
_____arthritis in fingers
_____decreased grip strength

ABDOMEN

_____nervous stomach
_____gas
_____constipation
_____diarrhea

GENERAL

_____nervousness
_____irritable
_____depressed
_____fatigue
_____run down feeling
_____loss of sleep
_____weight loss/gain

WOMEN ONLY

pregnant? Y or N
how many months?_____

Accident Questionnaire:

Date of your accident: _____________ What state did your accident occur? ________
What Type of accident (please check one): ___MVA ___Slip & Fall ___ Other

Please explain in detail how your accident happened:

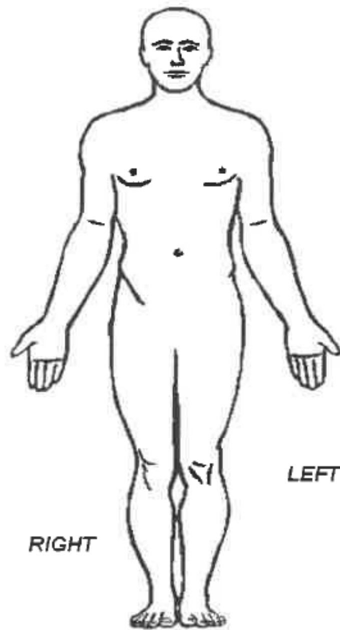
____
____
____
____

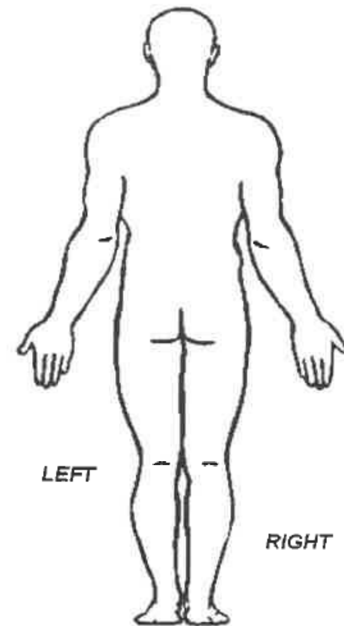
For Auto Accidents Only :
You were the: Driver_____ Front Passenger_____ Rear Passenger______
Were you wearing a seatbelt? Y N
You were struck from: Behind_____ Front_____ Left Side_____ Right Side_____

For All Accidents:
Did you feel pain immediately after the accident? Y N
Where? Headache _____Neck_____ Middle Back_____ Lower Back_____
Upper Extremities_____ Lower Extremities_____
Did you go to the Hospital or Urgent Care? Y N
If yes, did you go by ambulance? Y N
Have you received any treatment prior to coming to this office? Y N
If yes, what date? __________
Where? ____
What type of Treatment? ______________________________
Have x-rays been taken following this accident? Y N
If yes, where and of what body part? ___________________________
Have any MRI's or CT scans been taken following this accident? Y N
If yes, where and of what body part? ___________________________
Have you ever been in a automobile accident before? Y N
If yes, what date?____
If yes, are you having any residual pain? ______________________
Are you still under treatment for a prior accident? ________________
Are your work activities restricted as a result of this accident? Y N
Did you have to take time off work as a result of this accident? Y N
If yes, how many days have you missed as a result of this accident?__________
Have you returned to work since this accident? _____Full time _____Part time
_____Full duty _____Light duty
Is your sleep disturbed as a result of this accident? Y N
If yes, is it disturbed due to pain? Y N
How many hours do you sleep at night? __________
Is it difficult to sit, stand, walk, bend or lift as a result of this accident? Y N
How long can you:
Sit for?_______________ minutes or hours
Stand for?_______________ minutes or hours
Walk for?_______________ minutes or hours
Since this injury are your symptoms: _____worse _____the same _____better

Name: ____________________
Date: ____________________

Please clearly mark where you are having pain in the diagram to the right:





Please describe your overall pain:

_____Aching	_____Tender	_____Burning	_____Stabbing
_____Sharp	_____Nagging	_____Numb	_____Dull
_____Throbbing	_____Shooting	_____Tingling	

What is the frequency of your pain?

___Constantly ___Frequently ___Intermittent ___Occasionally

Please describe your pain on a scale from 1-10:

0	1	2	3	4	5	6	7	8	9	10
No pain									Extreme Pain	

Please describe your pain PER area:

Neck	0	1	2	3	4	5	6	7	8	9	10
Middle Back	0	1	2	3	4	5	6	7	8	9	10
Lower Back	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Shoulders	0	1	2	3	4	5	6	7	8	9	10
Elbows	0	1	2	3	4	5	6	7	8	9	10
Wrist/Hand	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Knees	0	1	2	3	4	5	6	7	8	9	10
Ankle/Foot	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10

DUTIES UNDER DURESS/LOSS OF ENJOYMENT QUESTIONNAIRE

Patient Name: ______________________________ Date: ___/____/20___

Complete the following summary as it relates to your work duties and your living duties and how the accident injury is **affecting** your overall performance at work and/or home. Check which activity is affected by the accident injury which requires you to reduce the time you are capable of performing these activities.

Job description: ______________________________

N/A	Work	Reason for the difficulty		
_____	lifting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	bending	□ Increased Pain	□ Restricted movement	□ Weakness
_____	sitting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	walking	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Computer duties	□ Increased Pain	□ Restricted movement	□ Fatigue
Other:	___________	□ Increased Pain	□ Restricted movement	□ Weakness

N/A	Studies/School	Reason for the difficulty		
_____	lifting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	bending	□ Increased Pain	□ Restricted movement	□ Weakness
_____	sitting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	walking	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Computer duties	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	studying	□ Increased Pain	□ Restricted movement	□ Fatigue
Other:	___________	□ Increased Pain	□ Restricted movement	□ Weakness

N/A	Domestic Duties	Reason for the difficulty		
_____	vacuuming	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Taking care of kids	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	cleaning	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Preparing Meals	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Other: _________	□ Increased Pain	□ Restricted movement	□ Fatigue

N/A	Household Duties	Reason for the difficulty		
_____	Yard work	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Transportation	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	shopping	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	taking out trash	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Other: ________	□ Increased Pain	□ Restricted movement	□ Fatigue

Plainfield CHIROPRACTIC & REHABILITATION LTD
dba Plainfield Spine And Rehab
13520 S. Route 59 Suite 100
PLAINFIELD, ILLINOIS 60544
PHONE: (815) 439-9800
FAX: (815) 439-9804
www.plainfieldchiroandrehab.com

DOCTOR'S LIEN

I do hereby authorize Plainfield Chiropractic & Rehabilitation LTD to furnish you, my attorney and/or responsible insurance party, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I acknowledge this letter by signing below at the doctor's office with the doctor present. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Dated______________________ ____
Physician Name & Signature

Dated______________________ ____
Patient Name & Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above-named.

Plainfield Spine And Rehab

13520 S Route 59, Suite 100
Plainfield, IL 60544
815 439-9800
Fax 815 439-9804

Authorization for the Disclosure/Request of Protected Health Information

Date: ___________________

Patient Name: ____________________________________ Date of Birth: ______________

I request and authorize the release my health care records or disclosure of information being requested to Plainfield Spine And Rehabilitation.

I certify that this request has been made voluntary and that the information given below is accurate to the best of my knowledge. I understand that I have the right to revoke this authorization by making a written request to Plainfield Spine and Rehab, at any time except to the extent that action has already been taken to comply with it. I understand that information released, disclosed, and/or used pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws and regulations.

Please release my records to Plainfield Spine and Rehabilitation:

____

____

____

____

____

____

____

____

____

Print and Signature of PATIENT

Paul McCarthy D.C.____

Print and Signature of DOCTOR

Insurance

This Information is needed to ensure 3rd party financial responsibility is billed and not the patient. Information is needed for clinic and attorney.

<u>3rd Party's Insurance (At Fault)</u>

Insurance Name:
Policy #:
Claim #:
Phone #:
Claim Adjusters Name:

<u>Medical Insurance Information (Personal Insurance)</u>

Insurance Name:
Group #:
ID #:

**Auto Accident Only, Not for work accident cases*
<u>Auto Insurance Information (Insurance of Vehicle)</u>

Insurance Name:
Policy #:
Claim #:
Phone #:
Claim Adjusters Name: