Back Pain, Neck Pain & Headache Relief Center

Gregory J. Valentine, D.C.

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AUTO ACCIDENT HISTORY FORM

PATIENT SECTION – Please Complete The Following Information

Patient:____Date:_______________

Where Were You Seated: ☐ Driver
☐ Passenger: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Middle

Date of Injury:_________________ Your Vehicle Year/Make/Model:________________________

Property Damage Estimate $____

Other Vehicle Make/Model:____

Describe how the accident occurred (please be as detailed as possible):____________________

____

____

____

____

Were you aware the impact was going to occur? ☐ No ☐ Yes
Did you brace for the impact? ☐ No ☐ Yes
Did you lose consciousness? ☐ No ☐ Yes

Were you wearing your seat belt? ☐ No ☐ Yes – Is there a ☐ Lap Belt ☐ Shoulder Harness
Did the air bags deploy? ☐ No ☐ Yes
Did you hit your head? ☐ No ☐ Yes, on the___________________________

Was your head rotated to the side at the point of impact? ☐ No ☐ Yes

Did you hit any part of your body on the interior of the vehicle upon impact? ☐ No ☐ Yes
Body Part: __________________________ Struck the ____________________________________

Were the police called? ☐ No ☐ Yes Was a police report made? ☐ No ☐ Yes
Were the paramedics called? ☐ No ☐ Yes Were you treated on scene? ☐ No ☐ Yes

Did you go to a hospital? ☐ No ☐ Yes: ☐ By ambulance ☐ Drove self
☐ Someone else took me

Date:_____________Hospital:____________________________________City_______________
X-Rays Taken: ☐ Yes ☐ No Medication Given:_________________________________
Treatment Rendered:____

Date:_____________First Doctor Seen:______________________________City_____________
X-Rays Taken: ☐ Yes ☐ No Medication Given:_________________________________
Treatment Rendered:____

Date:_____________Second Doctor Seen:____________________________City_____________
X-Rays Taken: ☐ Yes ☐ No Medication Given:_________________________________
Treatment Rendered:____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

AUTOMOBILE ACCIDENT HISTORY FORM – Page 2

PATIENT SECTION – Please Complete The Following Information

Patient:____

CURRENT COMPLAINTS:

Body Part:____
How often do you have this pain? ❑ Occasional (25% of time) ❑ Intermittent (50% of time)
❑ Frequent (75% of time) ❑Constant (100% of time)

How bad is this pain on a scale from 0-10? (see scale below)

No Pain: 0—1—2—3—4—5—6—7—8—9—10: Excruciating Pain

Where does this pain radiate to? ____

What activities make this pain worse? ____

Body Part:____
How often do you have this pain? ❑ Occasional (25% of time) ❑ Intermittent (50% of time)
❑ Frequent (75% of time) ❑Constant (100% of time)

How bad is this pain on a scale from 0-10? (see scale below)

No Pain: 0—1—2—3—4—5—6—7—8—9—10: Excruciating Pain

Where does this pain radiate to? ____

What activities make this pain worse? ____

Body Part:____
How often do you have this pain? ❑ Occasional (25% of time) ❑ Intermittent (50% of time)
❑ Frequent (75% of time) ❑Constant (100% of time)

How bad is this pain on a scale from 0-10? (see scale below)

No Pain: 0—1—2—3—4—5—6—7—8—9—10: Excruciating Pain

Where does this pain radiate to? ____

What activities make this pain worse? ____

Please list any additional pain or symptoms you are experiencing as a result of this accident:

____

____

____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

AUTOMOBILE ACCIDENT HISTORY FORM – Page 3

PATIENT SECTION – Please Complete The Following Information

Patient:____

Please check any of the following symptoms you have experienced since the accident occurred:

General Complaints:

- ❑ Ringing/Buzzing in ears
- ❑ Loss of: balance / memory
- ❑ Loss of: smell / taste
- ❑ Fatigue
- ❑ Chest pain
- ❑ Nervousness
- ❑ Irritability
- ❑ Pain behind eyes
- ❑ Anxiety
- ❑ Loss of sleep
- ❑ High stress levels
- ❑ TMJ
- ❑ Bruises:______________________
- ❑ Cold hands / feet
- ❑ Diarrhea / upset stomach
- ❑ Visual Disturbances
- ❑ Tension
- ❑ Shortness of breath
- ❑ Lights bother eyes
- ❑ Cold sweats
- ❑ Depression
- ❑ Dizziness
- ❑ Constipation
- ❑ Burns____
- ❑ Lacerations:_____________________________________

Other Complaints:____

Past Medical History:

Prior Injuries:

Prior Trauma/Accident/Injuries:____
Prior Automobile Accidents:____
Prior Work Injuries:____

General Health History: Check all condition you current have.

❑ Diabetic	❑ Epilepsy	❑ Chronic Depression
❑ Fibromyalgia	❑ Stroke	❑ Anxiety / Panic Attacks
❑ Neck Surgery	❑ Back Surgery	❑ Heart Attack / Cardiac Condition
❑ ______________	❑ _____________	❑ ____

Other:____
____

Prior Surgical History:

Date:________________Procedure:____
Date:________________Procedure:____
Date:________________Procedure:____

Medical History;

What medications are you currently taking for the symptoms relating to your accident?
____
____

What other medications are you taking for any other condition unrelated to this accident?
____
____

List any allergies to medication you have:____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

AUTOMOBILE ACCIDENT HISTORY FORM – Page 4

PATIENT SECTION – Please Complete The Following Information

Patient:____

Social History:
Your Age:______ Are you: ❑ Single ❑ Married ❑ Separated ❑ Divorced

How many children do you have? ____________ Do you smoke? ❑ No ❑ Yes

Please list any hobbies you have:
____

____

WORK HISTORY:

Employer at the time of the Injury:____

Occupation:____

Have you missed time from work as a result of this accident? : ❑ No ❑ Yes
If yes, please list the dates you missed from work:__________________________________
____

Describe your job duties in detail:____
____
____

Have you had any pain while performing your job duties that you did not have prior to this accident? ❑ No ❑ Yes

DUTIES UNDER DURESS:

Describe how the accident has affected your lifestyle:

With performing your work activities (pain with sitting, standing, bending, pushing, pulling, etc):

____

____

With performing domestic duties (laundry, dishes, vacuuming, cleaning, preparing meals, etc):

____

____

While participating in sports activities (running, amateur/professional athlete, etc.):

____

____

While vacationing or traveling (business or pleasure, cancelled travel plans, unable to sit, etc.):

____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

AUTOMOBILE ACCIDENT HISTORY FORM – Page 5

PATIENT SECTION – Please Complete The Following Information

ACTICITIES OF DAILY LIVING:

Please describe your ability perform the following daily living activities and qualities of life. If you have any problems performing any of them, please be as descriptive as possible in order to help determine how the injuries resulting from the accident have affected you.

Self Care – Hygiene:

❑ brushing teeth ❑ combing / fixing hair ❑ bathing
❑ dressing ❑ putting on socks or shoes

Other:____

Communication:

❑ problems with speech ❑ memory / concentration ❑ visual disturbances
❑ hearing ❑ TMJ – jaw popping

Other:____

Limitation of Activity:

❑ sleeping ❑ sitting ❑ standing ❑ walking ❑ running
❑ going up or down stairs

Other:____

Sensory:

❑ problems with touch ❑ loss of sensation in the:______________________________
❑ smell ❑ taste ❑ balance and coordination

____

Reduced Hand Function:

❑ finger motion ❑ hand control or motion ❑ weak grip
❑ dropping things ❑ tingling or numbness in hands

Other:____

Travel:

❑ duration of travel ❑ riding ❑ driving ❑ walking
❑ rough ground ❑ flying

Other:____

Sexual:

Are you having any difficulties or pain with sex? ❑ No ❑ Yes
If yes, please explain:____

____

Sleep Deprivation:

❑ interruption frequency ❑ interruption pain ❑ morning fatigue
❑ irritability ❑ reduced daytime alertness ❑ forgetfulness
❑ tension ❑ anxiety ❑ depression
❑ panic attacks ❑ shortness of breath ❑ nightmares

Other:____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

Notice of Personal Injury/ Third Party-Pay Accounts

Personal Injury/ auto versus auto, and or any third party pay accounts that are accepted with our office as a third party pay or personal medical lien are accepted according to the following stipulations:

Upon settlement with the third party payer (insurance company), the total outstanding balance must be paid in full within five (5) working days of receipt of settlement. It is customary that the third party payer issues the settlement checks to you, the patient, and that the payment is then paid to the treating chiropractor, by the patient.

If there is a dispute concerning the settlement, our office must be notified in writing and copy of the settlement agreement must be provided to our office for consideration.

If, you choose to have an attorney represent your case/claim at any time during or upon completion of your treatment, you are responsible for notifying our office and supplying the necessary information to your attorney for lien agreement and payment.

I fully understand that I am directly responsible for all my medical bills and that this agreement is made solely for the chiropractor/doctors protection and consideration of awaiting payment.

I accept that any default or non-payment regarding my account will be subject to any and all liability of small claims court and fees as well as reporting of said balance to ALL credit agencies.

I, also certify that no guarantee or assurance has been made regarding the outcome of my treatment or any settlement amounts of my case/ claim.

I have read, understood and agree to comply with the above statements.

______________________________ ______________________________

Signature of patient/ claimant **Date**

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(714) 738-0115 Fax (714) 738-3796

RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT:____

INSURED:____

DATE OF INJURY: ____

CLAIM # ____

POLICY #____

SOCIAL SECURITY #_______________________________________

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician listed above; As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my Attorney, should receive payment of my medical bill for the entirety of this claim.

Thank you for your cooperation in this matter.

____

Patient /Insured Signature

____

Printed Name

NOTICE OF DOCTOR'S LIEN

Patient: ______________________________ Date of Accident: __________

I do hereby authorize Dr. Gregory J. Valentine to furnish you, my attorney, 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, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered to 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 as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me that his 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 said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. 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 and may declare payment and /or the entire balance due and payable.

______________ ____

DATED PATIENT'S SIGNATURE

The undersigned being attorney for 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 and fully compensate said above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

______________ ____

DATED ATTORNEY SIGNATURE

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