InSight Health & Wellness

Automobile Accident Questionnaire

Accident Information

Name:_____ Date:_____

1. Date of Accident:_____ Time:_____ a.m./p.m.

2. Driver of car:_____ Where you were seated:_____

3. Owner of car:_____ Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: □ head-on collision □ broad-side collision □ rear-end collision

□ front impact, rear-ended car in front □ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? □ Yes □No

11. Did you brace for impact? □Yes □ No

12. Were you wearing a seatbelt? □ Yes □ No

13. Were you wearing a shoulder harness? □ Yes □ No

14. Does the car have headrests? □ Yes □ No

15. If yes, what was the position of your headrest? □ top of headrest even with bottom of head

□ top of headrest even with top of head □ top of headrest even with middle of head

16. Was your car braking? □ Yes □ No Was the other car braking? □Yes □ No

17. Was your car moving at the time of the accident? □ Yes □ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

1601 Walnut Street, Suite 514, Philadelphia, PA 19102 215-564-6680 insighthealthwellness.com

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19. What was the position of your head and body at the time of impact?

□ head turned left/right □ body straight in sitting position □ head looking back

□ body rotated left/right □ head straight forward □ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: □ rendered unconscious □ dazed □ other: _____

22. Could you move all parts of your body? □yes □ no

If no, why? _____

23. Were you able to get out of the car and walk unaided? □ yes □ no

If no, why? _____

24. Did you have any cuts or bruises from this accident? □ yes □ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that □ day □night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

□ headache	□ loss of smell	□ numbness in fingers	□ neck pain/stiffness
□ loss of taste	□ cold hands	□ mid-back pain	□ loss of memory
□ cold feet	□ low-back pain	□ fatigue	□ diarrhea
□ tension	□ constipation	□ pain behind eyes	□ shortness of breath
□ chest pain	□ dizziness	□ irritability	□ nervousness
□ fainting	□ depression	□ cold sweats	□ anxious
□ sleeping problems	□ loss of balance	□ numbness in toes	
□ ringing/buzzing in ears		□ eyes sensitive to light	□ other:_____

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27. Have you missed time from work? □ yes □ no Work hours are: □ full-time □ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? □ yes □ no

29. Did you seek medical help immediately/soon after the accident? □ yes □ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen:_____Date: _____

31. What was done? _____

Were x-rays taken? □ yes □ no If yes, of what body part? _____

32. What treatments/prescriptions were given? □ bed rest □ brace □ adjustments □ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

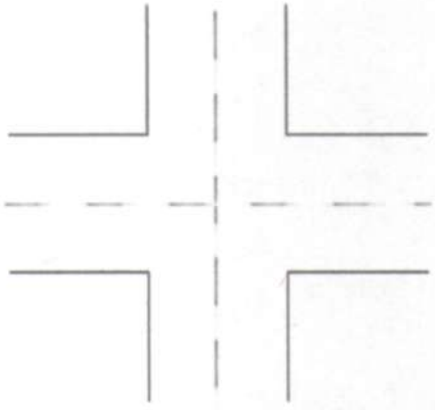
35. Are any of your activities of daily living any different now compared to before the accident?
□ yes □ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

_____

InSight Health & Wellness

_____

_____

37. Do you have an attorney handling this case? □ yes □ no

If yes, who? (name/address)_____

_____

Insurance Information

Patient's PERSONAL insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address:_____City:_____State/Zip:_____

Claim #:_____

Adjuster's name/phone:_____

OTHER party's insurance: _____

Insured's name (if other than patient)_____Policy #: _____

Insurance Company Name:_____Phone#: _____

Address:_____City:_____State/Zip: _____

Claim #: _____Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address:_____City:_____State/Zip: _____

InSight Health & Wellness

Claim #: _____

Adjuster's name/phone: _____

Patient's Information

Patient's full name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

Mailing address (if different): _____

Phone: _____ Email address: _____

Marital Status: _____ Patient's Occupation: _____

Employer's Name: _____

Employer's address: _____

Work phone #: _____ Work Email address: _____

Spouse's name: _____

Spouse's Social Security #: _____ Spouse's Email: _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **InSight Health & Wellness** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **InSight Health & Wellness** the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay **InSight Health & Wellness** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____

InSight Health & Wellness
Personal Health History

Patient: Date of Birth:

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Low blood press.
- ☐ ☐ ☐ High blood press.
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

O F C

Genitourinary
- ☐ ☐ ☐ Freq. urination
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Prostate trouble

Eye, Ear, Nose & Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain

Gastrointestinal
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult Digest.
- ☐ ☐ ☐ Gallbladder
- ☐ ☐ ☐ Stomach Pain
- ☐ ☐ ☐ Vomiting

Skin
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Skin rash
- ☐ ☐ ☐ Varicose veins

O F C

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Difficult breathing

Women only
- ☐ ☐ ☐ Cramps/backache
- ☐ ☐ ☐ Heavy flow
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Menstrual Pain

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Lumbago
- ☐ Multiple sclerosis
- ☐ Pacemaker
- ☐ Stroke
- ☐ Ulcers

Describe chiropractic problem: _____

_____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No

Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)

What seemed to be the initial cause?

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _____
For what reason?

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No For serious injury? ☐ Yes ☐ No

Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?

Indicate the drugs do you now take? ☐ Birth control pills ☐ Tranquilizers ☐ Pain Killers ☐ Other (specify)

Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes?

What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable?

How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Have you ever:

- Had a broken bone: ___Yes ___ No. If yes, explain briefly:_____
- Been hospitalized: ___ Yes ___ No. If yes, explain briefly: _____
- Had strains or sprains __ Yes ___ No. If yes, explain briefly: _____
- Used a cane, crutch or other support ___Yes ___ No. Explain: _____
- Been struck unconscious: ___Yes ___No. Explain: _____

When did you last have:

- Spinal Xray: ___ Never ___ 0-6 Months ___6-18 Months ___ Longer
- Spinal Exam ___ Never ___ 0-6 Months ___ 6-18 Months ___ Longer
- Physical Exam: ___ Never ___ 0-6 Months ___ 6-18 Months ___Longer

Habits:

	None	Light	Moderate	Heavy
- Alcohol:				
- Coffee:				
- Tobacco:				
- Drugs:				
- Exercise:				
- Sleep:				
- Water:				

FOR WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No If yes, how many months?
How many children do you have?

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

_____

_____

_____

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

_____ _____

Patient (or Guardian) Signature Date

Revised Oswestry Questionnaire

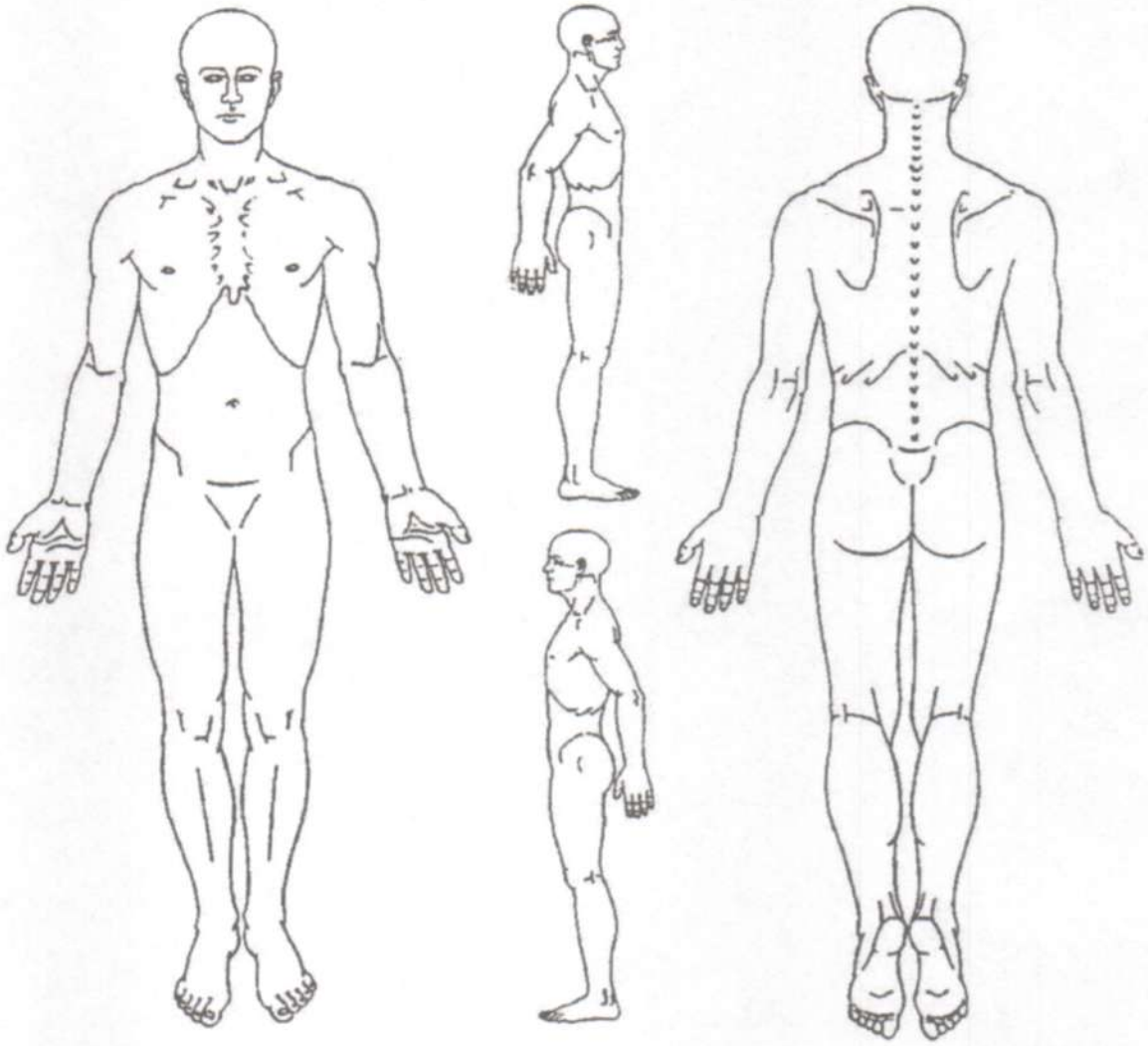
Age:_____Date of Birth:_____ Occupation:_____

How long have you had these symptoms? _____years ____months _____weeks

Is this your first episode of these symptoms? _____yes ___no

PLEASE USE THE LETTERS TO DESIGNATE THE AREAS OF DISCOMFORT:

A = Ache	B = Burning	N = Numbness
P = Pins and needles	S = Stabbing	O = Other



Revised Oswestry Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much the pain you are experiencing has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I manage if they are conveniently positioned, e.g., on a table.
3. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Walking

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than one mile.
2. Pain prevents me from walking more than 1/2 mile.
3. Pain prevents me from walking more than 1/4 mile.
4. I can only walk while using a cane or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

0. I can sit in any chair as long as I like without pain.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than ten minutes.
5. Pain prevents me from sitting at all

Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than ten minutes without increasing pain.
5. I avoid standing, because it increases the pain.

Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain, my normal night's sleep is reduced by less than one-quarter.
3. Because of pain, my normal night's sleep is reduced by less than one-half.
4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social life

0. My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of my pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of pain.

Section 9 – Traveling

0. I get no pain while traveling.
1. I get some pain while traveling, but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me from all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but overall is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Comments:

Patient signature: _____ Date: _____

InSight Health & Wellness
Your Health is Our Vision

Notice of Privacy Practices For Protected Health Information

HIPAA

- This notice describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY!

The Federal Government passed a new law in August 2002 dealing with the privacy of patient records. The new law is called Health Insurance Portability and Accountability Act. HIPAA for short. This is our general consent form. Again, review it carefully.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or staff member at Insight Health & Wellness (IHW) may have to disclose your health information, including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment protocol of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party such as an insurance carrier, HMO, PPO or your employer if they are potentially responsible for the payment of your services.
3. Your chiropractor or staff member of IHW may need to use your health information, examination/treatment records and/or your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor or staff member of IHW may need your name, address, phone number, fax number or cell number as well as your clinical records to contact you and provide appointment reminders, information about treatment alternatives or changes, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or cell voice mail.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we may use to contact you to provide appointment reminders, information about treatment alternatives, changes in treatment protocols or other health related information at any time.

Our Privacy Pledge

We have and always will respect your **PRIVACY.** Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization.

Under FEDERAL law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

Insight Health & Wellness c/o Wendy Kreifels
1601 Walnut Street, Suite 514
Philadelphia, Pa. 19102

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make your request IN WRITING.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be IN WRITING.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be IN WRITING and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- Those disclosures made to you.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- Those disclosures for national security or government intelligence purposes.
- Those disclosures made to correctional officers or law enforcement agents.
- Those disclosures that were made prior to the effective date of the HIPPA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you IN WRITING when you come in for your next treatment encounter or by U.S. mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal privacy rules.

Your right to complain

You may complain to us or to the Secretary for Health and Human Services (HHS) if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Insight Health & Wellness c/o Wendy Kreifels
1601 Walnut Street, Suite 514
Philadelphia, Pa. 19102

To contact us

If you would like further information about our privacy policies and practices, please contact:

Insight Health & Wellness c/o Wendy Kreifels
1601 Walnut Street, Suite 514
Philadelphia, Pa. 19102
215-564-6680

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice and that it was explained to me.

_____ _____
Patient Name Printed **Date**

_____ _____
Patient Signature **Authorized Provider Rep**

_____ _____
Personal Representative printed **Personal Representative Signature**

_____
Description of Personal Representative's Authority to act for the Patient.