burien wellness

PATIENT INFORMATION

Date _____

Name _____ _____ _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday ___/___/___

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Insurance Provider _____

Prefix and ID# _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

_____

HOW CAN WE HELP YOU?

What brings you in today? ☐ Wellness ☐ Pregnancy ☐ Accident ☐ Physical Complaint

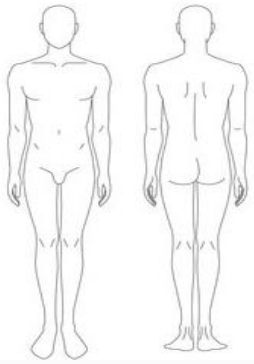
What brings you in today?_____

How long has this been an issue?_____

How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Aching ☐ Sharp
☐ Tingling ☐ Cramping ☐ Shooting
☐ Stiffness ☐ Nagging ☐ Burning
☐ Dull ☐ Stabbing ☐ Throbbing
☐ Swelling ☐ Other_____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

Immediate _____

Short Term _____

Long Term _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

_____

Are you currently pregnant? ☐ No ☐ Yes, due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

_____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you **have** or **have had**.

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer
☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Gout
☐ Headaches/Migraines
☐ Heart Disease
☐ Hepatitis
☐ Hip Issues
☐ Immune Issues
☐ Lymphatic Issues
☐ Multiple Sclerosis
☐ Neck Pain
☐ Reproductive Issues
☐ Ringing in Ears
☐ Scoliosis
☐ Shoulder Issues
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Please list below.

ALLERGIES_____ MEDICATIONS_____ SUPPLEMENTS_____

_____ _____ _____

_____ _____ _____

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Motor Vehicle Accident: Questionnaire

This questionnaire will allow you to describe your motor vehicle accident in detail. Please complete it carefully as the information provided will assist the doctors in evaluating and documenting your condition. Please choose any and all answers that apply.

PATIENT & INCIDENT INFORMATION

Today's Date _____

Name _____ _____ _____ What was the date of the accident? _____
Last First Middle Initial

In your own words, please briefly describe what happened:

_____

_____

What was your position in the vehicle at the time of the accident?

- ○ Driver
- ○ Front Side Passenger
- ○ Left Rear Side Passenger
- ○ Right Rear Side Passenger

What type of vehicle were you in? _____

What type of vehicle was the other party driving?

_____

What type of restraint were you wearing at the time of impact?

- ○ Lap Belt
- ○ Shoulder Harness
- ○ Both
- ○ None

What was your vehicle doing at the time of impact?

- ○ Moving
- ○ Stopped
- ○ Slowing Down

How was the vehicle impacted?

- ○ From the Rear
- ○ Head On
- ○ From the Left Side
- ○ From the Right Side
- ○ Obliquely from the Front Left Side
- ○ Obliquely from the Front Right Side
- ○ Obliquely from the Rear Left Side
- ○ Obliquely from the Rear Right Side

How would you describe the damage to your vehicle?

- ○ Minimal
- ○ Moderate
- ○ Extensive
- ○ Totaled
- ○ Unsure

Right after the incident, did you feel any of the following? (please check all that apply)

- ○ Disoriented
- ○ Confused
- ○ Neck Pain
- ○ Mid Back Pain
- ○ Low Back Pain
- ○ Felt Fine

Were police called to the scene? Yes No

Immediately after the accident, what did you do?

- ○ Drove Home
- ○ Drove to Emergency Room
- ○ Was Driven Home
- ○ Was Driven to ER

When did the symptoms you are experiencing now begin?

- ○ Immediately
- ○ A Few Hours Later
- ○ Next Day
- ○ Several Days Later
- ○ A Week Later
- ○ 2 or More Weeks Later

Did you strike any of the following?

- ○ Steering Wheel
- ○ Dashboard
- ○ Windshield
- ○ Side Window
- ○ Back of Front Seat
- ○ Not Sure
- ○ None
- ○ Other: _____

Did you experience any of these symptoms prior to the accident? Yes No

Have you sought any other medical treatment for your injuries? Yes No

If so, who have you seen?

- ○ Medical Doctor
- ○ Chiropractor
- ○ Massage Therapist
- ○ Physical Therapist
- ○ Acupuncturist
- ○ Other: _____

Clinic or Provider's Name: _____ Prior to the accident, had you ever experienced any of these symptoms before?

- ○ None
- ○ Headaches
- ○ Chronic Nausea
- ○ Neck Pain
- ○ Mid Back Pain
- ○ Low Back Pain
- ○ Hip or Pelvic Pain
- ○ Upper Extremity Pain
- ○ Lower Extremity Pain

Name (Print): _____

Signature: _____ Date: _____

Motor Vehicle Accident: Insurance Verification

In order to assist with the process of verifying your insurance so that we may begin your care in our office, we ask that you obtain all of this information for us prior to your second visit. This ensures that there is no financial barrier to receiving the necessary care in the aftermath of a car accident.

The first step is to call your insurance company to open a claim, if you have not already done so at the time of the accident. Their number can be located on your insurance card or on the company's website.

Insurance Company: _____ Phone: (____) _____-_____

Billing Address: _____City_____ State _____ Zip _____

Your Auto Policy #: _____ Claim #: _____

When you open a claim, you will be assigned a claims adjuster to handle your case. Their job is to determine the extent of the company's liability. Many auto policies contain a provision for **Personal Injury Protection (PIP)**. Ask your adjuster or another representative from the company whether or not your policy has PIP coverage, and in what amounts. Typically, policies with PIP coverage will usually pay 100% of your expenses for chiropractic care. If your balance is paid in full by the insurance company, there will be no out of pocket expense to you.

Adjuster's Name: _____ Adj.'s Phone: (____) _____-_____

Adjuster's Email: _____

PIP on policy? YES NO PIP Coverage Limit: $_____**Office Use Only**:_____

If you do not have PIP coverage on your auto insurance policy, and you were not at fault in the accident, you may choose to hire an attorney in order to seek a settlement from the other party's insurance. We **do not** bill the third-party insurance directly, so in order to hold a balance until a settlement can be reached, we must have a letter of representation signed by your attorney in order to begin a care plan in our office. If you do not already have an attorney, we are happy to recommend one.

Attorney's Name: _____ Att.'s Phone: (____) _____-_____

Attorney's Email: _____

If you have neither personal injury coverage nor an attorney, you will be on a cash basis.

Should the insurance company fail to pay, and reasonable efforts were made to collect, you will then be responsible for payment in full of any accrued balance.

Name (Print): _____

Signature: _____ Date: _____