

# Automobile Accident Questionnaire

## Please Answer All Questions Completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answer will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Preferred Contact No. Hm. \_\_\_\_\_ Wk. \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician's Name \_\_\_\_\_ Primary Care Physician's Phone \_\_\_\_\_

Email \_\_\_\_\_ Do you give us permission to contact you by e-mail/and or send you an email newsletter? Yes \_\_\_\_\_ No \_\_\_\_\_

Occupation/Company Name \_\_\_\_\_ Business Phone Number \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security No. \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

Please explain in detail how your accident happened

Do you have Personal Injury Protection (PIP)?  Yes  No If so, what is the name of your Car Insurance? \_\_\_\_\_

Claim No. \_\_\_\_\_ Adjuster's Name \_\_\_\_\_ Adjuster's Telephone No. \_\_\_\_\_

Driver of other vehicle (If Any) \_\_\_\_\_ Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Claim No. \_\_\_\_\_ Adjuster's Name \_\_\_\_\_ Adjuster's Telephone No. \_\_\_\_\_

Have you retained an attorney? Yes  No  If so, name and address \_\_\_\_\_

Did your accident take you completely by surprise? Yes  No

Immediately prior to impact, were you looking straight ahead?  to the right  or to the left  Was head straight up?  or down?

Did any part of you hit anything inside your car? Yes  No  If so, what part(s) hit? \_\_\_\_\_

Did your car strike or get hit by any other car? Yes  No  If so, what was struck? \_\_\_\_\_

Give time and date present injury occurred: Date \_\_\_\_\_ Time \_\_\_\_\_ am \_\_\_\_\_ pm \_\_\_\_\_

Were you heading North  East  South  West on \_\_\_\_\_ (street or highway)

Other vehicle was headed North  East  South  West on \_\_\_\_\_ (street or highway)

Were police notified? Yes  No

Were you knocked unconscious? Yes  No  If so, for how long? \_\_\_\_\_

Were you struck from Behind  Front  Left Side  Right Side

Were you Driver  Passenger  Front Seat  Back Seat  Using seat belts  Other protective devices

Where did you feel pain immediately after the accident? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Did you consult any other doctor after your accident? Yes  No

If so, give doctor's name \_\_\_\_\_ D.C., M.D., D.O., D.D.S.

Doctor's diagnosis \_\_\_\_\_

What treatments did you receive? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_

How long did you see the doctor? \_\_\_\_\_

Have you ever had any complaints in the involved area before? Yes  No  If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others of your age? Yes  No

Are your work activities restricted as a result of this accident? Yes  No

Since this injury are your symptoms Improving?  Getting worse?  The same?

# Neck Index

Form N1-100

rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck 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

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

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

## Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

## NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:** \_\_\_\_\_

# Back Index

Form B1100

rev 3/27/2003

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.

## 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.

## 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.

## 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.

## 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.

## 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 (e.g., dancing, etc).
- ⓒ 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

Back  
Index  
Score

## BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
Examiner

**CLIFFORD CHIROPRACTIC NEUROLOGY CENTER**

5519 Arapaho Rd., Suite 108 Dallas, Texas 75248

(972) 934-1660 Fax (972) 934-1633

**NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_

**ACKNOWLEDGEMENT:**

I hereby acknowledge that I have received a copy of the above-identified provider's Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement for Consent to use Disclosure of Protected Health Information  
Use and Disclosure of your Protected Health Information:**

Your Protected Health Information will be used by Clifford Chiropractic Neurology Center or disclosed to other for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices:**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information:**

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of your protected information in violation of an agreed upon restriction will be in violation of the Federal Privacy Standards.

**Revocation of Consent:**

You may revoke this consent to the use or disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practice:**

This office reserves the right to modify the privacy practices outlined in the Notice

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Others we may release your PHI to: \_\_\_\_\_

**CLIFFORD CHIROPRACTIC NEUROLOGY CENTER  
DR. ROGER CLIFFORD**

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of chiropractic care:**

The primary treatment used as a Doctor of Chiropractic is Chiropractic Manipulative Therapy. I will most likely use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you've experienced when you "crack" your knuckles. You may feel a sense of movement. I may also use ancillary procedures such as EMS, interferential, cold laser, intersegmental traction, deep tissue massage, and rehabilitative exercises. Diagnostic procedures may also be used, including: X-rays, range of motion testing, and orthopedic and neurological testing.

**The material risks inherent in chiropractic adjustment:**

As with any health care procedure, there are certain complications which may arise including, but not limited to: Fractures, disc injuries, dislocations, muscle strain, myelopathy, costovertebral strains, burns, and strokes. The incidences are exceedingly rare. In fact, a 2008 study in the journal Spine showed no more risk of stroke than visit to primary care physicians. I take precautions and use techniques to help make the treatments as safe as possible. There are also risks attendant to remaining untreated. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort to screen for contra-indications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**I HAVE READ [ ] OR HAVE HAD READ TO ME [ ] THE ABOVE EXPLANATION OF CHIROPRACTIC CARE. I HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION. BY SIGNING BELOW I STATE THAT I HAVE WEIGHED THE RISKS INVOLVED IN UNDERGOING TREATMENT AND HAVE DECIDED THAT IT IS IN MY BEST INTEREST TO UNDERGO THE TREATMENT RECOMMENDED. HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT TO THAT TREATMENT.**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Signature of Patient, Parent, or Guardian (if a minor)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_  
**Date**

## CLIFFORD CHIROPRACTIC NEUROLOGY CENTER

### Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to this facility the following rights, power and authority.

**IRREVOCABLE ASSIGNMENT OF RIGHTS:** You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

**DEMAND FOR PAYMENT:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bills for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation.

**THIRD PARTY LIABILITY:** If my injuries are the results of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

**STATUE OF LIMITATIONS:** I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

**LIMITED POWER OF ATTORNEY:** I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

**TERMINATION OF CARE WAIVER:** I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time.

**A photocopy of this instrument shall serve as original.**

Signature of Patient and/or responsible party:

### Office Policy Regarding Insurance Assignment

Our office will accept your insurance on assignment. However, it must be understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policies regarding assignment:

- 1) At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office DOES NOT guarantee your insurance policy or payments. We highly recommend that you contact your insurance company so you are aware of your benefits. Our office will not be responsible for any misquote of benefits.
- 2) You will be responsible for your deductible and co-payment. If your insurance does not pay something that was anticipated you will be responsible for the amount as soon as we/you are aware of the denial.
- 3) By taking insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that you insurance company does not pay on a timely basis, you may be asked to pay.
- 4) If you're insurance company mails a check directly to you for our services, you must bring the misdirected check into our office within 48 hours.

**I have read and understand the Assignment of Benefits and the Policy Regarding Insurance Assignment; I realize that I am responsible for all charges incurred by me at this office.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date