

## Auto Accident Questionnaire

---

*name* *today's date* *date of accident*

---

*date of birth* *age* *gender* *marital status* *# of children*

---

*address* *street* *city* *state* *zip*

---

*home phone* *cell phone* *email*

---

*occupation* *company name* *city* *work phone*

---

*spouse or guardian's name* *occupation* *company name* *city*

---

*social security #* *drivers license #* *how did you hear about us?*

---

### Auto Insurance Information (please present a copy of your auto insurance card)

---

**your** *auto insurance company* *insured's name* *policy #*

---

*address* *street* *city* *state* *zip*

---

*adjustor's name* *phone # / ext.* *med pay claim #*

---

**other** *person's auto insurance company* *insured's name* *policy #*

---

*address* *street* *city* *state* *zip*

---

*adjustor's name* *phone # / ext.* *claim #*

**Health Insurance Information (please present your health insurance card)**

---

*health Insurance company*                      *insured's name*                      *policy #*

---

*address*                      *street*                      *city*                      *state*                      *zip*

---

---

**Auto Accident Injury Circumstances**

---

*was the crash on the job*                      *which seat were you in*                      *vehicle driven by(name)*

---

*your vehicle make/model/year*                      *your estimated speed at moment of crash*                      *owner of car(name)*

---

*other vehicle make/model/year*                      *vehicle driven by(name)*                      *their estimated speed at moment of crash*

---

*time of day?*    *road conditions(dry, ice, etc.)*    *what part of your car was hit?*    *what part of the other car hit you?*

---

*your headrest (adjustable,integral,none,)*    *was the top of the headrest even with top, middle, or bottom of your head*

---

*was the seat back adjustment altered by the crash?*    *was the seat broken?*    *wearing your seat belt?*    *airbags deployed?*

---

*struck by the airbag?*    *Your body position(forward lean, side tilt, twisted, etc.)*    *head position(forward, down, turned)*

---

*where were your hands at the time of impact?*    *Brakes applied?*    *Where you aware of the impending collision?*

---

*at impact, did your body hit anything, console,steering wheel, etc.?*    *did the vehicle strike anything after impact?*

---

*wearing hat, glasses?*                      *Were they still on after the crash?*                      *Did you lose consciousness?*

*Please explain the accident*

Diagram the accident by using rectangles for vehicles. Please label the names of the streets, and directions (N,S,E,W).

**After the Crash – Check All Problems Experienced Since the Accident**

Headache	Low back pain	Knee pain	Cold feet	Loss of sleep	Fatigue
Dizziness	Neck pain	Ankle pain	Cold hands	Loss of balance	Diarrhea
Nausea	Shoulder pain	Foot pain	Cold sweats	Depression	Stiffness
Confusion	Elbow pain	Numbness	Fainting	Mid back pain	Ear Ringing
Disorientation	Hand pain	Tingling	Tension	Constipation	Chest pain
Memory loss	Hip pain	Loss of taste	Spasms	Nervousness	Light sensitive

*please list other problems you are or have experienced since the accident (jaw, menstrual, cuts, bruises, etc.)*

*What is the estimated property damage to your vehicle? How much damage to the other vehicle(minor,moderate, maj.)*

*Did police arrive at the scene? Was there a ticket given to anyone? Was there a report made? Were pictures taken?*

*Where did you go after the crash?(home, work, hosp.doctor)*

*Name of Hospital/doctor/Clinic?*

*What tests were performed at the (hosp./clinic/doctor)?*

*Results?*

*Were prescriptions prescribed or given?*

*Please list the recreational activities you enjoy. List how often you did them. List how they are currently affected.*

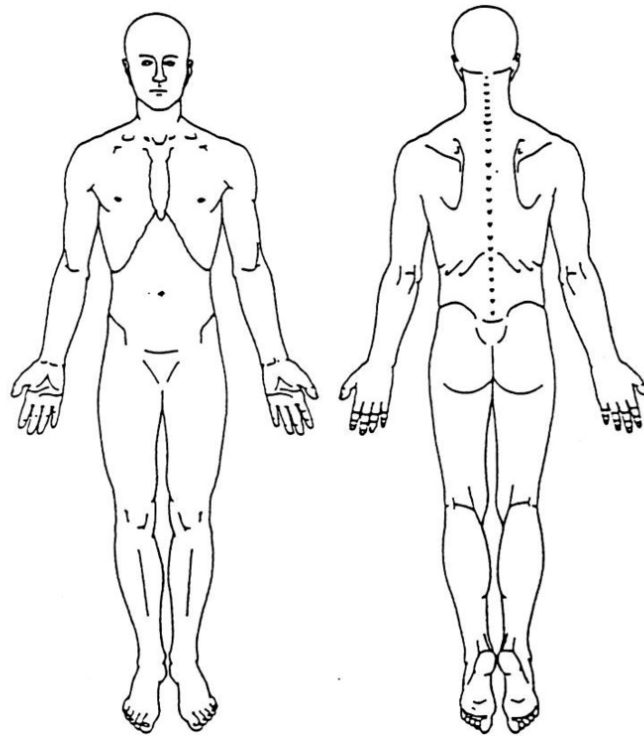
*Please list activities around the house that are more difficult now (doing dishes, laundry, getting dressed, bathing, etc.)*

*List any past fractures, surgeries, serious illnesses, workers' comp injuries, other auto injuries, or sports injuries.*

*List the current medications/supplements you are taking. Allergies? Are you pregnant? Last known height and weight.*

*Who's your primary care physician? \_\_\_\_\_ Phone \_\_\_\_\_*

Use the diagram to indicate all areas of pain, discomfort, numbness, or problems caused by your accident.



Denver Chiropractic, LLC

## Consent to Examination and Treatment

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Trent Artichoker, DC and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Trent Artichoker, DC. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

## Our Privacy Policy

The office of Dr. Trent Artichoker, DC is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Trent Artichoker, DC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my confidential medical information above is correct to the best of my knowledge.

Denver Chiropractic, LLC

Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please print your name \_\_\_\_\_

## ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

**THIS AGREEMENT, entered into this date \_\_\_\_\_ and between \_\_\_\_\_ called “PATIENT” and Denver Chiropractic, LLC\.**

WHEREAS Patient desires to receive chiropractic services form Denver Chiropractic, LLC and desires to assign certain rights and benefits to Denver Chiropractic, LLC as consideration for Denver Chiropractic, LLC awaiting payment of such benefits.

Accordingly, it is hereby agreed:

- A. Patient hereby authorizes Denver Chiropractic, LLC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of patients such persons as Denver Chiropractic, LLC deems appropriate.
- B. Patient’s assigns to Denver Chiropractic, LLC any and all benefits payable by Patient’s insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by Denver Chiropractic, LLC. Patient also assigns to Denver Chiropractic, LLC any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Denver Chiropractic, LLC.
- C. Patient fully understands that Patient is directly and fully responsible to Denver Chiropractic, LLC for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patients further understands that such payment is not contingent on any settlement, claim, judgment, or verdict which Patients may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Denver Chiropractic, LLC. Patient agrees to be responsible for any such outstanding balance, including interest at a rate 9%, reasonable attorney’s fees and costs.
- D. Patient fully understands that the lien and assignment given to Denver Chiropractic, LLC herein is irrevocable.
- E. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to Denver Chiropractic, LLC. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to Denver Chiropractic, LLC. Denver Chiropractic, LLC is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, Denver Chiropractic, LLC is providing care and treatment for which this lien, assignment and directive provides security for payment. *Moreover*, Patient agrees that Denver Chiropractic, LLC is to be viewed as a third party beneficiary of this direction to Patient’s attorney and it is Patient’s intent to impose upon Patient’s attorney an obligation to comply with the terms of this directive.
- F. Patient hereby directs all insurers and other persons possibly responsible for Patient’s healthcare costs to make all payments for healthcare services rendered by Denver Chiropractic, LLC directly to Denver Chiropractic, LLC.
- G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for Denver Chiropractic, LLC and will immediately deliver said check, draft, or payment to Denver Chiropractic, LLC to be applied to Patient’s debt for services rendered.
- H. Patient hereby appoints Denver Chiropractic, LLC as Patient’s true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient’s name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by

Denver Chiropractic, LLC. Denver Chiropractic, LLC is not obligated or compelled to exercise such powers but may do so in Denver Chiropractic, LLC sole discretion. Patient agrees to fully cooperate with Denver Chiropractic, LLC in collecting said amounts.

- I. Denver Chiropractic, LLC agrees to submit a copy of this agreement with the initial claim form(s) which Denver Chiropractic, LLC submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.
- J. Patient hereby authorized Denver Chiropractic, LLC to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions. It is our policy, that if the patient does not have med pay on their auto insurance policy, and is being treated on a lien, we will not bill your health insurance. The reimbursement from your health insurance will not cover the extra time put fourth documenting your injuries.
- K. A copy of these documents shall be as binding as the document bearing the original signatures.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Denver Chiropractic, LLC  
Dr. Trent Artichoker MS, DC

**REFERENCES:**

*Valley State Bank V. Dean*, 97 Colo. 151, 47 P. 2<sup>nd</sup> 924 (1935)  
*Fort Lupton State Bank v. Murata*, 626 P.2d 757 (Colo. App. 1981)  
*Barcucas v. Bohemia Import Co., Inc.*, 518 P.2d 850 (Colo. App. 1974)  
*Thomas v. Oken*, 699 P2d (Colo. App. 1984)

Denver Chiropractic, LLC

## Neck Disability Index

Date \_\_\_\_\_

### **Pain Intensity** (Circle One)

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is very moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

### **Personal Care- Washing, Dressing etc** (Circle one)

- A. I can look after myself normally, without causing extra pain.
- B. I can look after myself normally, but it causes extra pain.
- C. It is painful to look after myself, but I am slow and careful.
- D. I need some help but manage most of my care.
- E. I need help everyday with every aspect of my self-care.
- F. I do not get dressed, I wash with difficulty and I stay in bed.

### **Lifting** (Circle One)

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but can lift if they are conveniently positioned such as a table.
- D. Pain prevents me from lifting heavy weights but I can manage light/medium weights if they are conveniently positioned.
- E. I can only lift light weights.
- F. Pain prevents me from lifting weight from the floor.

### **Reading** (Circle One)

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want to with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I can't read as much as I want because of the moderate pain in my neck.
- E. I can hardly read at all because of the severe pain in my neck.
- F. I cannot read at all.

### **Headaches** (Circle one)

- A. I have no headaches at all.
- B. I have slight headaches, which come in-frequently.
- C. I have moderate headaches, which come in-frequently.
- D. I have severe headaches, which come frequently.
- E. I have moderate headaches, which come frequently.
- F. I have headaches almost all the time.

### **Concentration** (Circle One)

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair amount of difficulty when concentrating.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

### **Work** (Circle one)

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I can't do any work at all.

### **Driving** (Circle one)

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight neck pain.
- C. I can drive my car as long as I want with moderate neck pain.
- D. I can't drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I can't drive my car at all.

### **Sleeping** (Circle one)

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed.
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is greatly disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

### **Recreation** (Circle one)

- A. I am able to engage in all of my recreation activities with no neck pain at all.
- B. I am able to engage in all of my recreational activities, with some neck pain.
- C. I am able to engage in most, but not all of my usual activities because of neck pain.
- D. I am able to engage in a few of my activities because of pain in my neck.
- E. I can hardly do any of my recreational activities because of pain in my neck.
- F. I can't do any recreation activities at all.

## Low Back Disability Index

Date \_\_\_\_\_

### Pain Intensity (Circle one)

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

### Personal Care (Circle one)

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

### Lifting (Circle one)

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

### Walking (Circle one)

- A. Pain does not prevent me from walking any distance.
- B. I have some pain with walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than 1/2 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet

### Sitting (Circle one)

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all

### Standing (Circle one)

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away

### Sleeping (Circle one)

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

### Social Life (Circle one)

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social, life to my home.
- F. Pain prevents me from social, life at all.

### Traveling (Circle one)

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

### Changing Degree of Pain (Circle one)

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.