Tim Yoder, D.C.
Yoder Chiropractic Center P.S.
16111 SE McGillivray Blvd. Ste A
Vancouver, WA 98683 (360) 254-0994

Personal Injury Questionnaire

About You:

Name:_____Social Security #:_____-_____-_____
Address:_____
City:_____ State:_____ Zip:_____
Phone Home:_____ Work:_____Page/Cell:_____
Age:_____Birth date:_____Height:_____Weight:_____
R/L Handed (Circle) Occupation:_____Employer:_____
Employer Address:_____
Please check one: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name:_____Age:_____Birth date:_____
Number of children:_____Names & Ages:_____
Who referred you to our clinic (be specific):_____

Your Auto Insurance Co:_____Policy #:_____
Claim #:_____
Insurance Address:_____Insurance Phone:_____
Have you retained an attorney? ☐ No ☐ Yes Name:_____Attorney's Phone #:_____
Were there any witnesses? ☐ No ☐ Yes Names:_____
Were the police notified? ☐ No ☐ Yes Investigation by:_____
Who was at fault in the accident? ☐ Self ☐ Driver of car you were in ☐ Other driver

About Other Driver:

Driver of Other Vehicle:_____Phone #:_____
Claim #:_____Policy #:_____
His/Her Insurance Co._____
Insurance Address:_____
Insurance Phone #:_____

Accident Information:

1. Date of Accident?_____Time of Day?_____☐ AM ☐ PM
2. Were you: (Check One) ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in **your** vehicle?_____ # of people in **other** vehicle?_____
4. Road conditions at accident? ☐ Wet ☐ Dry ☐ Icy ☐ Other
   Road surface? ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other_____
5. What direction were **you** headed? ☐ N ☐ S ☐ E ☐ W
   Name of street or hi-way?_____
6. **Other car** direction? ☐ N ☐ S ☐ E ☐ W Name of street or hi-way?_____
   _____

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7. Were **you** struck from : ☐ Behind ☐ Front ☐ Left side ☐ Right side

8. Were **you** wearing a seat belt? ☐ No ☐ Yes **If yes-** ☐ Lap belt ☐ Shoulder belt ☐ Both
   ☐ Any bruising or soreness from belt? ☐ No ☐ Yes if yes explain_____
   _____

9. Did **your** airbags activate? ☐ No ☐ Yes ☐ Car does not have airbags
   Any bruising or soreness from the airbag? ☐ No ☐ Yes **if yes**, explain_____
   _____

10. **Your** position at time of impact? ☐ Facing forward ☐ Head turned-- ☐ Right ☐ Left

11. Does **your** car have a headrest? ☐ No ☐ Yes If yes, about how far was the top of the headrest from the top of your head? _____inches ☐ Above ☐ Below

12. Were **you** knocked unconscious? ☐ No ☐ Yes **If yes**, for how long_____

13. Were **you** aware of approaching impact? ☐ No ☐ Yes ☐ Surprised
    If yes, did **you** brace for impact? ☐ No ☐ Yes, how ?_____

14. Was **your** car stopped at time of impact? ☐ Yes ☐ No
    If yes, was **driver's** foot on the Brake Pedal? ☐ Yes ☐ No ☐ Unsure
    On the Clutch Pedal? ☐ Yes ☐ No ☐ Unsure
    If yes, did **your** car move forward on impact? ☐ Yes ☐ No ☐ Unsure
    If car was moving at the time of impact were **you** (check one) ☐ Gaining speed ☐ Slowing down
    ☐ Traveling at steady speed.

15. What was **your Cars** approximate speed?_____miles per hour

16. Did **your vehicle** hit a second car? ☐ No ☐ Yes
    Another object? ☐ No ☐ Yes Explain_____

17. Was the **other vehicle** moving at time of collision? ☐ No ☐ Yes
    If yes, how fast was the **other vehicle** traveling?_____miles per hour
    If yes, was the **other vehicle**? (check one) ☐ Gaining speed ☐ Slowing down ☐ Traveling steadily

18. What type/make of car were **you** driving or a passenger?_____

19. What type/make of the **other car**?_____

20. In your own words, please describe the accident, include what you heard, saw or felt._____
    _____
    _____
    _____

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21. Please describe how you felt: Did you feel pain?
    a. DURING the accident?_____
    _____
    b. IMMEDIATELY AFTER the accident?_____
    _____
    c. LATER THAT DAY?_____
    _____
    d. THE NEXT DAY?_____
    _____

22. Intensity: Pain Scale

No Pain----------Worst Pain Imaginable

At its best:	0---1---2---3---4---5---6---7---8---9---10
At its worst:	0---1---2---3---4---5---6---7---8---9---10
Now:	0---1---2---3---4---5---6---7---8---9---10

23. Estimated cost of damage to your vehicle?_____Do you have a photo showing damage? ☐ Yes ☐ No

24. CHECK which of the following body parts were hit/injured during the accident.
    - ☐ Head hit
    - ☐ Chest hit
    - ☐ R/L shoulder hit
    - ☐ R/L arm hit
    - ☐ R/L hip hit
    - ☐ R/L leg hit
    - ☐ R/L knee hit
    - ☐ Other_____

25. Check which of the following car parts were damaged **by your body** during the accident.
    - ☐ Windshield
    - ☐ R/L side window
    - ☐ Steering wheel
    - ☐ Front seat
    - ☐ Other_____

26. Did you have any physical complaints **BEFORE THE ACCIDENT**? ☐ No ☐ Yes
    If yes, describe in detail._____
    _____

27. Do you have any congenital (from birth) factors, which relates to this problem? ☐ No ☐ Yes
    If yes, explain._____
    _____

28. Do you have any previous illnesses relating to this case: ☐ No ☐ Yes
    If yes, explain_____

29. Have you ever been involved in an accident before: ☐ No ☐ Yes
    If yes, describe including dates, type of accident, and injury(s) received._____
    _____
    _____

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30. Did you receive **emergency care IMMEDIATELY** following this accident? ☐ No ☐ Yes
If yes, where, type of treatment, doctor's name._____
_____
Were you taken by ambulance to a hospital? ☐ No ☐ Yes

31. Have you been treated by another doctor since the accident? ☐ No ☐ Yes
If yes, list doctor's name and treatment:_____
_____

32. Since this injury occurred, are symptoms: ☐ Improving ☐ Getting worse ☐ Same

33. Check the symptoms that you have noticed **since** the accident:

☐ Arm Pain	☐ Ears Ringing	☐ Headache	☐ Loss of Taste	☐ Nervousness
☐ Chest Pain	☐ Elbow Pain	☐ Head Seems Heavy	☐ Loss of Memory	☐ Numbness in Arms
☐ Cold Hands	☐ Face Flushing	☐ Hip Pain	☐ Low Back Pain	☐ Numbness in Fingers
☐ Cold Sweats	☐ Fatigue	☐ Irritability	☐ Mid Back Pain	☐ Numbness in Legs
☐ Depression	☐ Fainting	☐ Leg Pain	☐ Knee Pain	☐ Shortness of Breath
☐ Diarrhea	☐ Fever	☐ Lights Bother Eyes	☐ Neck Pain	☐ Sleeping Problems
☐ Dizziness	☐ Foot Pain	☐ Loss of Smell	☐ Neck Stiffness	☐ Shoulder Pain
☐ Pins/Needles in Arms		☐ Pins/Needles in Legs	☐ Upper Back Pain	☐ Wrist Pain

Please list any SYMPTOMS other than ones above._____
_____

34. Have you lost time from work as a result of the accident: ☐ No ☐ Yes
If yes, when were you off from work? From_____ to_____
Are you being compensated for lost time? ☐ No ☐ Yes- Medical release ☐ No ☐ Yes

35. Since the accident do you notice any activity restrictions in your capacity for:
Work? ☐ No ☐ Yes explain _____
_____
Family? ☐ No ☐ Yes explain _____
_____
Recreation?: ☐ No ☐ Yes explain _____
_____

36. Other pertinent information? _____
_____

37. Do you smoke cigarettes? ☐ Yes ☐ No **IF Yes,** for how long?_____
Did you smoke cigarettes? ☐ Yes ☐ No IF Yes, for how long?_____

38. Do you have a substance or alcohol abuse problem? ☐ Yes for how long?_____ ☐ No
Did you have a substance or alcohol abuse problem? ☐ Yes for how long ago ?_____ ☐ No

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Have you ever had any of the following problems?

☐ Yes ☐ No Anemia
☐ Yes ☐ No Artificial Bones/ Joints
☐ Yes ☐ No Artificial Valves
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer/ Chemotherapy
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Diabetes/ Tuberculosis (TB)
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting
☐ Yes ☐ No Fever/ Fever Blisters
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Heart Problems/ Heart Murmur
☐ Yes ☐ No Heart Attack/ Stroke
☐ Yes ☐ No Heart Surgery
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Herpes
☐ Yes ☐ No High/Low blood pressure
☐ Yes ☐ No HIV/ AIDS
☐ Yes ☐ No Intestinal problems
☐ Yes ☐ No Kidney problems
☐ Yes ☐ No Liver problems
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Psychiatric problems
☐ Yes ☐ No Radiation treatment
☐ Yes ☐ No Rheumatic fever
☐ Yes ☐ No Scarlet fever
☐ Yes ☐ No Seizures
☐ Yes ☐ No Severe/ Frequent Headaches
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Stomach problems
☐ Yes ☐ No Ulcers/ Colitis
☐ Yes ☐ No Venereal Disease

Have you had any of these problems in the last 6 months?

☐ Yes ☐ No Abdominal cramps
☐ Yes ☐ No Ankle swelling
☐ Yes ☐ No Blood pressure problems
☐ Yes ☐ No Constipation
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Discolored urine
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Ear aches
☐ Yes ☐ No Excessive pain with urination
☐ Yes ☐ No Excessive thirst
☐ Yes ☐ No Frequent nausea/ vomiting
☐ Yes ☐ No Headaches
☐ Yes ☐ No Heart problems
☐ Yes ☐ No Lung problems
☐ Yes ☐ No Menstrual cycle dysfunction
☐ Yes ☐ No Poor/excessive appetite
☐ Yes ☐ No Sinus congestion/ allergies
☐ Yes ☐ No Vision problems

Have you had any major surgeries? ☐ Yes ☐ No
Please list with dates:_____

Have you had any serious health conditions? ☐ Yes ☐ No
Please list with dates:_____

Are you pregnant? ☐ YES ☐ NO --When was the first day of your last menstrual cycle? __/__/__

The above information is true to the best of my knowledge. I accept and acknowledge responsibility for all charges I incur at this office. All fees are payable at the time services are rendered. I hereby authorize Back to Health Chiropractic Clinic to release my insurance carrier information required for my claim.

Signature:_____ **Date:**_____

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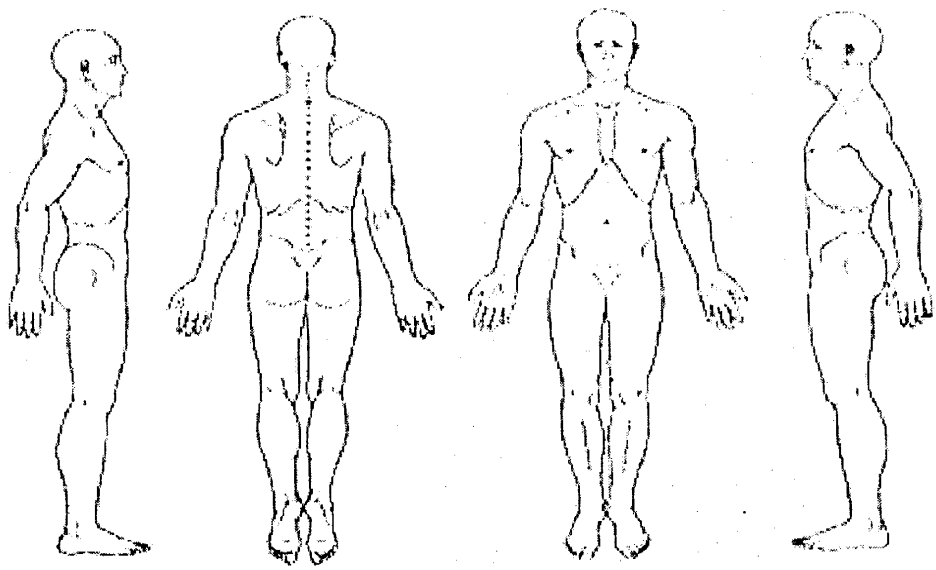
COMPLETE THE FOLLOWING:

39. Please fill in current complaint areas by placing the appropriate abbreviated letter on the people diagrams below:

P=Pain
B=Burning
S=Stiffness
T=Tingling
N=Numbness



40. Please diagram the accident including street names, car directions, street signs etc.

North

West **East**

South

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REQUEST FOR X-RAYS & INFORMATION

To: _____ I, _____

Social Security Number: _____ - _____ - _____ Birthdate: ____/____/____

Request the following information:

- ❑ X-RAYS, DIAGNOSTIC SCANS
- ❑ REPORTS
- ❑ RECORDS INCLUDING CHART NOTES
- ❑ INSURANCE INFO, PIP COVERAGE AND IME REPORTS

Date range: from _____ to _____

Concerning my:

- ❑ ACCIDENT DOI: _____
- ❑ ILLNESS

To be released to:

Dr. Timothy Yoder
16111 SE McGillivray Blvd., Ste A
Vancouver, WA 98683
(360) 254-0994 Fax (360) 254-0930

I authorize any doctor, hospital, employer, insurer or other person, to whom a signed, original or photocopy of this authorization is delivered, to furnish the above checked information. I understand that I have the right to receive a copy of this authorization upon my request. This authorization shall remain valid for one year from the date signed.

Signature: _____ Date: _____

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Effects of Massage

1) More flexibility
2) Improves circulation
3) Breaks down or prevents formation of adhesions
4) Reduces danger of fibrosis
5) Relives muscle tension
6) Increase blood & nutritional supply muscles
7) Removal of waste product (this helps overcome fatigue)
8) Improves muscle & skin tone & elasticity
9) Helps prevent or delay muscle atrophy
10) Strengthens the entire muscular system
11) Helps return venous blood to the heart
12) Blood circulation increases white blood cells, blood pressure decreases
13) Increases number of red blood cells ,especially in cases of anemia
14) Increases lymph flow, aiding the body in the elimination of wastes & toxins in the fluid, this aids the cells in their ability to receive nutrients & oxygen

MASSAGE POLICY:

We are happy that you are choosing massage therapy to help regain your health. Due to the limited availability in the massage therapy schedule book, we have certain guidelines regarding unexcused absences.

If you are unable to make your appointment please call at least **24 hours** in advance .If you call **24 hours** in advance we can easily fill that appointment with another patient.

An unexcused absence is missing an appointment without calling **24 hours** in advance. Of course, emergency absences are excepted. However, if it is not and emergency then you will be charged a **$25.00 non-refundable fee.** If you miss 3 appointments that are classified as unexcused then you will need to pre pay for your massages appointments at the time of scheduling.

I have read the above statements, and agree to them.

Signature: _____ Date: _____

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care. It is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. It will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expressions of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statement.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

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IRREVOCABLE ASSIGNMENT OF INSURANCE PAYMENTS AND TORT DAMAGES AND IRREVOCABLE LETTER OF INSTRUCTION

Date of Injury: _____

Patient's Name: _____

Party Causing Injury: _____

Other Party's Insurance: _____

TO: YODER CHIROPRACTIC CENTER PS

1. In exchange for Yoder Chiropractic Center providing care until insurance coverage or tort damages are available to pay for treatment charges, I agree to irrevocably assign Yoder Chiropractic Center any payments now or hereafter due me from any insurance company, attorney or third party responsible for my injuries. I also irrevocably instruct and request those parties pay any sums due me directly to Yoder Chiropractic Center, up to the amount of my unpaid bill.

2. I also irrevocably instruct my attorney to pay Yoder Chiropractic Center directly for any amount I owe in connection with my injuries from the proceeds of any settlement or verdict obtained on my behalf, whether or not the damages recovered are categorized as general or special damages.

3. I agree that a photocopy of this document, including my photocopied signature, will be as valid and binding on all parties involved as the original.

DATED THIS _____ day of _____ 20_____.

_____
PATIENT'S SIGNATURE

_____
PARENT OR LEGAL GUARDIAN FOR CLINIC'S PATIENT

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We have prepared the following financial policy in order to help our patients determine their responsibility for payment of chiropractic and massage therapy services.

Please check the box(s) that apply to you and sign at the bottom.
PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

O HEALTH INSURANCE (Major Medical Coverage): Once insurance coverage is verified, we will be happy to bill your insurance company for you! You will be required to pay the amount not covered by your insurance company at each office visit.

° A Telephone quote usually is the way we obtain medical benefit and eligibility information however this does not necessarily mean your insurance company will approve treatment nor guarantee payment of services.

° There is a possibility your insurance company has a deductible; if this pertains to you then it is your responsibility to pay for any portion that your insurance company does not cover. You can make arrangements to make payments for your deductible, co-payments and any other portion your insurance company does not cover.

O PERSONAL INJURY PROTECTION (PIP) AND AUTO ACCIDENTS: Cases will be billed directly to the insurance company, provided paperwork has been filled out correctly and claim has been filed.

° If auto accident was not your fault you still must notify your insurance company so they are aware of accident and can provide you with a claim number for your medical bills to be paid. This is a standard procedure with insurance companies; your insurance company will pay your medical bills up front and will be re-reimbursed from the at-fault insurance company when your claim is settled.

° Even if the other insurance company agrees to pay for your medical bills, they have no obligation to pay them, and will exercise that right leaving you responsible for your medical bills.

O WORKERS COMPENSATION: Workers compensation claims will be billed directly to the insurance company, provided the paperwork has been filled out correctly and claims has been filed. IF YOU ARE DENIED WORKERS COMPENSATION, YOU WILL BE RESPONSIBLE FOR ALL BILLS INCURRED.

O MEDICARE: Please be advised that Medicare-B will only pay for spinal adjustments and there is a 20% co-payment. THEY WILL NOT PAY FOR EXAMS AND X-RAYS.

O PRIVATE PAY: If you do not have health insurance, you will be responsible for health care expenses and we will make sure your accounts are kept current or have made payment arrangements that are suitable for all parties.

° OUR OFFICE'S "CASH" FEES ARE POSSIBLE DUE TO THE MINIMAL AMOUNT OF PATIENT BILLING REQUIRED. WE ASK THAT YOU PLEASE HAVE YOUR PLAN AMOUNT READY ON THE DATE IT IS DUE.

° We will be periodically be updating our accounts so if there is any discrepancy we will let you know right away so you can keep your account current. If you have a credit balance, we will inform you, at which time you can request a refund or leave the credit to be applied to future charges.

We believe this is a clear definition of our financial policy and it will allow us all to continue to concentrate on the most important issue you health and well- being.

I have read and understand the above financial policy:

Signature:_____ **Date:**_____

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Acknowledgement of Protected Health Information Regulations

I, _____, consent to the release of protected health information that is required to carry out treatment and payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Yoder Chiropractic Center is not required to agree with my request restrictions. I also understand that once Yoder Chiropractic Center agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Yoder Chiropractic Center must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Yoder Chiropractic Center has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly: and we will inform you by providing you with a new notice.

Individual:	Witness:
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date