MECHANISM OF INJURY:

According to Warner et al, when an automobile is struck from behind, a ramping effect is created, thereby causing the occupants of the automobile to move upward. This causes the headrest to now strike the head at a lower angle, creating a fulcrum for increased hyperextension of the neck. This increases the injury. **(Warner CY, Stother CE, James MB, Decker RL Occupant protection in rear-end collisions:II. The role of seat back deformation in injury reduction. 35th Stapp Car Crash Conference, 1991; SAE 912914)**

According to Mertz and Patrick, the unaware occupant is at a greater risk of injury. **(Mertz HJ, Patrick LM. Investigation of the kinematics and kinetics of whiplash. 1967; SAE 670919.)**

Radanov and Sturzenegger found that patients who had rotated or inclined head position were much more likely to have symptoms at 2 years post-injury than those with a straight-on head position. **(Radanov BP, Sturzenegger M. The effect of accident mechanisms and initial findings on the long-term outcome of whiplash injury. Journal of Musculoskeletal Pain 1996;4(4):47-59.)**

According to Luo and Goldsmith, a small car can experience much higher accelerations in a minor impact and therefore increase the injury. **(Luo Z, Goldsmith W. Reaction of a human head/neck/torso system to shock. Journal of Biomechanics 1991;24;7;499-510.)**

According to Luo and Goldsmith, the faster and heavier the rear car is moving, the more severe the forces placed on the occupant in the front car. **(Luo Z, Goldsmith W. Reaction of a human head/neck/torso system to shock. Journal of Biomechanics 1991;24;7;499-510.)**

According to Allen, Barnes and Bodiwala, shoulder belts are very effective at saving lives in auto accidents, but there is some evidence that they can actually cause more damage in a rear end collision. Because the body is held in place, the neck suffers worse hyperflexion. The cervical spine may also undergo a twisting motion from the head restraint, causing a more complex injury. **(Allen MJ, Barnes MR, Bodiwala GG. The effect of seat belt legislation on injuries sustained by car occupants. Injury: The British Journal of Accident Surgery 1985; 16; 471-476).**

A study by Radanov found that patients who reported pain immediately after their accidents were more likely to have pain at two years post-injury. It is generally recognized that patients with immediate symptoms are at a higher risk of long-term pain from whiplash. **(Radanov BP, Sturzenegger M, De Stefano G. Long-term outcome after whiplash injury. A two-year follow-up considering the features of injury mechanisms and somatic, radiologic and psychosocial findings. Medicine 1995; 74(5): 281-296.)**

Address___________________________________City_________________ State
___________ Zip Code ____________

H. Phone _____________________________W. Phone_________________ Cell Phone
____

Email Address: ________________________

Sex M F Marital Status M S D W Date of Birth_______________
Age____________

Social Security #_______________________________________
Occupation____
____

Employer____
____

Date of Accident__________________ Description of
Accident____

Emergency Intervention (When)________________(Where)______________________
Radiographs/CAT Scans/MRI Yes or No
*Your Auto Insurance*____________________________ Lawyer
Y/N_______________________ Phone_______________________

Claim #________________________ Adjustors Name_________________________
Phone_______________________
Other Auto Insurance**____________________________ Claim**
#_______________________ Phone____________________

Medical Insurance Information
1) Insurance Company:_______________________ (Primary) 2) Insurance
Company:_____________________ (Secondary) 1) Phone: ______________ Member
ID:________________ 2) Phone: _____________ Member ID: ________________
1) Group: _________ Name________________ DOB________ 2) Group: _________
Name________________ DOB________
1) Deductable________ Met Y/N__________ Co-pay_________ 2) Deductable________
Met Y/N__________ Co-pay_________

Have you ever received Chiropractic Care? Yes No If yes, when?
____
Name of most recent Chiropractor:
____
_

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
   ____
   ____
   ____
   ____
   ____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts:
      ____

   B. Visual Disturbance : yes/no (please explain):
      ____

   C. Dizziness: yes/no How often:
      ____

   D. Anxiety: yes/no How often:
      ____

   E. Depression: yes/no How often:
      ____

   F. Difficulty Sleeping: yes/no How often:
      ____

3. **Past Health History:**

   A. Please indicate if you have a history of any of the following:
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other ___________
   □ None of the above

   B. Previous Injury or Trauma:
   ____
   ____

   C. Have you ever broken any bones? Which?
   ____
   ____

   C. Allergies:
   ____
   ____

D. Medications:

Medication Reason for taking

____
____
____
____
____
____

E. Surgeries:

Date Type of Surgery

____
____
____
____
____
____
____
____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____
____
____
____
____
____
____
____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes

□ Other _______________ □ None of the above

Deaths in immediate family: ____

Cause of parents or siblings death
Age at death
____
____

5. Social and Occupational History:

A. Job description: ____

B. Work schedule: ____

C. Recreational activities: ____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): ____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ____________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements
□ Diabetes
□ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control)
□ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other
_______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain
□ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture
□ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other
_______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? ___________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Gregg Friedman, DC, PLC/Arcadia Spinal Health Center for services performed.

Patient or Guardian Signature
____

Date_________________________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________________________ ________________________

Signature of Patient of Representative Date

____

NEW PATIENT HISTORY FORM

Symptom 1 ______________________________________

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _______________________________________
    - Did you have this symptom before this motor vehicle collision? Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending

forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ________________________

- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________________
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? ________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 ____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? ____
    - Did you have this symptom before this motor vehicle collision? Yes/No

- If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, walking, pain medication, muscle relaxers, nothing, Other (please describe): ___________________________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
    Other (please describe):

____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________

- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 ____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? ____

- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? ____
- Did you have this symptom before this motor vehicle collision? Yes/No
  - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ________________________

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
    Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ________________________________

- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 ____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin?
  ____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin?
    ____

  - Did you have this symptom before this motor vehicle collision? Yes/No

    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    ____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
    ____

- Describe the quality of the symptom (circle all that apply):

  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
    Other (please describe):
    ____

- Does the symptom radiate to another part of your body (circle one): yes no

  - If yes, where does the symptom radiate?
    ____

- Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 5 ____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? ___________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 ____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? ____
    - Did you have this symptom before this motor vehicle collision? Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): __________________________
- What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
    Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________

- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day