Bean Chiropractic
1754 36th Street
Sacramento, CA 95816
(916) 475-1263

OFFICE USE ONLY

PATIENT # _____

DATE _____

CONFIDENTIAL PATIENT INFORMATION

ACCIDENT REPORT

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of this form. If you need any help, please ask the receptionist.

PATIENT DATA

(First name, middle initial, last name) **SOCIAL SECURITY #** _____ **DRIVER'S LICENSE #** _____

NAME _____ **HOME PHONE** _____ **EMERGENCY PHONE** _____

HOME ADDRESS _____ **CITY** _____ **ZIP CODE** _____

MAILING ADDRESS _____ **CITY** _____ **ZIP CODE** _____

AGE _____ **BIRTHDATE** _____ **MARITAL: M S W D** **HOW MANY CHILDREN?** _____

OCCUPATION _____ **EMPLOYER** _____

EMPLOYERS' ADDRESS _____ **OFFICE PHONE** _____

NAME OF SPOUSE OR PARENT (circle one) _____ **OCCUPATION** _____

SPOUSE OR PARENTS' EMPLOYER _____ **OFFICE PHONE** _____

PATIENT'S NEAREST RELATIVE (other than spouse) _____ **RELATIONSHIP** _____

RELATIVE'S ADDRESS _____ **CITY** _____ **ZIP CODE** _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

DATE OF LAST PHYSICAL EXAM _____

WHAT OPERATIONS HAVE YOU HAD & WHEN? _____

SERIOUS ILLNESSES _____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? _____

INSURANCE DATA:

Name of person (s) responsible for payment _____

Do you have Auto Insurance? ❑ No ❑ Yes Company's Name _____

Please list all sources of insurance:

- Group Insurance _____ (Name) EMPLOYEE I.D. NO. _____
- Spouse's Insurance _____ (Name) POLICY NO. _____
- Workmen's Compensation _____ (Name) GROUP NO. _____
- Others _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's
Signature Authorizing Care _____ Date: _____

Information Taken By: _____ Date: _____

—PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO—

HEALTH QUESTIONAIRRE: CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE YOUR ACCIDENT/INJURY

SYMPTOMS:

HEAD:
- ❑ Headache
- ❑ entire head
- ❑ back of head
- ❑ forehead
- ❑ temples
- ❑ migraine
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Ringing in ears

NECK:
- ❑ Stiff neck
- ❑ Muscle spasms in neck
- ❑ Grinding sounds in neck
- ❑ Pain in neck
- ❑ Neck pain with movement

SHOULDERS:
- ❑ Pain in shoulder joint (R-L)
- ❑ Pain across shoulders
- ❑ Bursitis (R-L)
- ❑ Arthritis (R-L)
- ❑ Can't raise arm
- ❑ above shoulder level
- ❑ over head
- ❑ Tension in shoulders

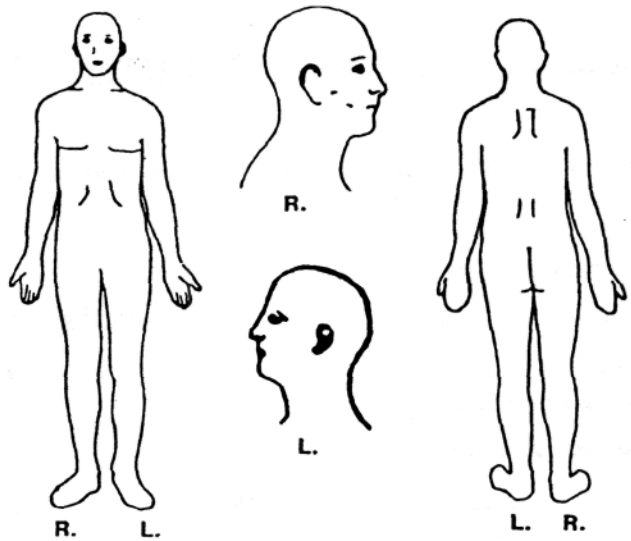
ARMS & HANDS:
- ❑ Pain in upper arm
- ❑ Pain in forearm
- ❑ Pain in hands
- ❑ Pain in fingers
- ❑ Sensation of pins & needles in arms
- ❑ Sensation of pins & needles in fingers
- ❑ Fingers go to sleep
- ❑ Hands cold
- ❑ Loss of grip strength

MID-BACK:
- ❑ Mid-back pain
- ❑ Pain between shoulder blades
- ❑ Sharp stabbing pain in mid-back
- ❑ Muscle spasms

LOW BACK:
- ❑ Low back pain
- ❑ Low back pain is worse when:
- ❑ working
- ❑ lifting
- ❑ stooping
- ❑ standing
- ❑ sitting
- ❑ bending
- ❑ coughing
- ❑ Low back feels out of place
- ❑ Muscle spasms
- ❑ Arthritis

HIPS, LEGS & FEET:
- ❑ Pain in buttocks (R-L)
- ❑ Pain in hip joint (R-L)
- ❑ Pain down leg (R-L)
- ❑ Pain down both legs
- ❑ Leg cramps
- ❑ Pins & needles in legs (R-L)
- ❑ Numbness of leg (R-L)
- ❑ Numbness of feet (R-L)
- ❑ Numbness of toes
- ❑ Feet feel cold
- ❑ Cramps in feet (R-L)
- ❑ Swollen ankles (R-L)
- ❑ Swollen Feet (R-L)

*Mark Areas of Pain on Figures in Red and Rate Your Pain: 0 (least) - 10 (severe)
*Mark Areas of Tingling/Numbness in Blue



CHEST:
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs

GENERAL:
- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue
- ❑ Generally feel run-down
- ❑ Loss of sleep
- ❑ Loss of weight

ABDOMEN:
- ❑ Nervous stomach
- ❑ Nausea
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea

Briefly describe symptoms you are presently suffering from: _____

_____

_____

Other Doctors seen for this/these conditions _____

History of present injury-Date: _____ Approximate hour _____ (AM) (PM)

Have you lost any days work? From _____ To _____

If other than auto injury, describe how injury occurred _____

_____

If auto injury fill out the following information: Driver _____ Passenger _____ Front _____ Back _____

Patient's car was going: Direction _____ Street or Road _____

Closest bisecting street or road (if any) _____ Town _____

Numbers of autos involved in accident _____ Number of persons _____

Was patient moving _____ Stopped _____ Turning _____ Right or Left? _____

State exactly where your car was struck (side, rear, front, etc.) _____

Did you see the accident coming? _____ Were seat belts worn? _____

Upon accident, which way were you thrown? _____

Upon impact was there a "blinding" or "explosion" sensation in the head? _____

State which areas of your body were hurt immediately after the accident _____

_____

Were you able to get out of the car and walk? _____

Were you conscious at all times? _____ Could you move all parts of your body? _____

Was a police report made? _____

Was an ambulance called for you? _____ Did you go to the hospital? _____

If so, what was done: X-rays _____ Examination _____ Medications _____

How long were you in the hospital? _____ Were you able to sleep that night? _____

What discomfort did you have the first night? _____

The next day? _____

FINANCIAL AGREEMENT
PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBLE:
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MED PAY: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
3rd PARTY: If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment.Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please, don't hesitate to ask.

I have read and agree to the above

_____ _____

Patient's Signature Date

Sidney B. Bean, D.C. **Bean Chiropractic**
1754 36th Street
Sacramento, CA 95816
(916) 475-1263 .Fax (916) 475-1863

Re: MEDICAL REPORTS AND PROVIDER/DOCTOR'S LIEN

I do hereby authorize BEAN CHIROPRACTIC OFFICE, to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident hi which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries hi connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and hi consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate hi protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Dated_____ _____

Patient's Signature

The undersigned attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above-named.

Dated_____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name_____ Date_____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just* ***mark the one box*** *which most closely describes your problem right now.*

SECTION 1- Pain Intensity

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 comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2- Personal Care

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 increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain I am unable to do any washing or dressing without help.

SECTION 3- Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me 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 a 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.

SECTION 4- Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5- Sitting

A. I can sit in any chair as long as I like without pain.
B. I can sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____

_____

SECTION 6- Standing

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 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7- Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
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 the pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8- Social Life

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 interest, 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. I have hardly any social life because of the pain.

SECTION 9- Traveling

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.

SECTION 10 – Changing Degree of Pain

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.

_____Examiner

Fairbank J, Davies J, et al. The Oswestry Back Pain Disability Questionnaire. Pysiotherapy 1980;66(18):271-273.