Today's Date: ____/ ____/ _____
Date of Accident: ____/ ____/ _____

AUTO ACCIDENT HISTORY

WELCOME: The doctors and staff welcome you and want to provide you with the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you with your care. If we do not believe that your condition will respond to our treatments, we will refer you to the appropriate healthcare provider. If you are a candidate for our treatments, a customized plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following questions to the best of your ability. Be as descriptive as possible and check all descriptors that apply. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

Confirm Date of Accident: ____/ ____/ _____

First Name: _____
Middle Name: _____
Last Name: _____
Birth Date: ___/ ___/ ___ Gender: _____
Address: _____
_____
City: _____
State: _____ Zip Code: _____

Primary Phone: _____
☐Work ☐Cell ☐Home
Secondary Phone: _____
☐Work ☐Cell ☐Home
Email: _____

EMERGENCY CONTACT INFORMATION

First Name: _____
Last Name: _____
Phone Number: _____
Relationship: _____

YOUR AUTO INSURANCE INFORMATION

- Have you filed a claim with your auto insurance? ☐Yes. Claim Number_____ ☐No
- Do you have an attorney?
  ☐Yes. Name of Your Attorney_____ Phone Number: _____
  ☐No, I do not need one. ☐ No, I would like an attorney.
- Do you have Med-Pay: ☐Yes ☐No ☐Not Sure
- Auto Insurance Carrier: _____
- Auto Insurance Phone Number: _____
- Claim Adjuster's Name: _____ Your Policy Number: _____
- Do you have health insurance? ☐Yes ☐No

RESPONSIBLE PARTY'S AUTO INSURANCE INFORMATION

- Auto Insurance Carrier: _____
- Auto Insurance Phone Number: _____
- Auto Insurance Claim Number: _____

AUTO ACCIDENT HISTORY (cont'd)
WHAT IS THE REASON FOR YOUR VISIT?

_____

_____

_____

_____

When did your symptoms appear? _____

Is this condition getting? ☐Better ☐Worse ☐No Change

Please check the types of pain that apply to you: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other _____

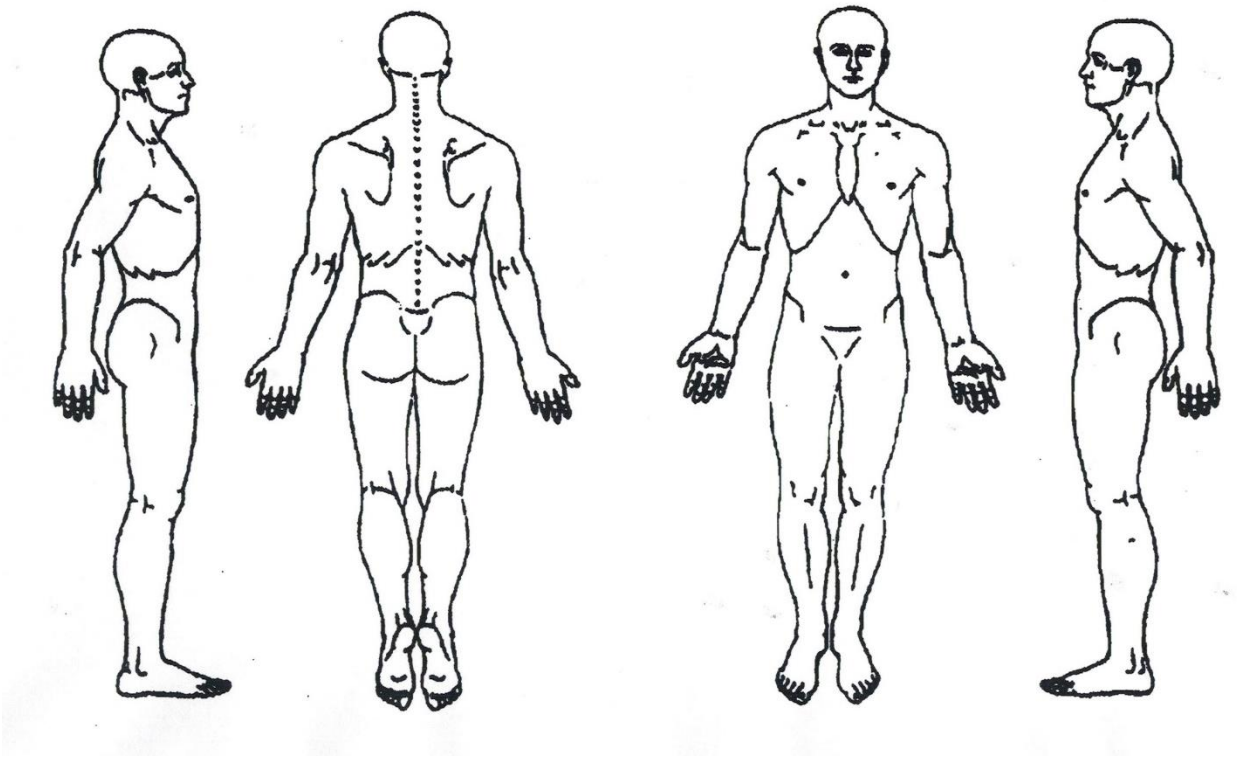
Is the pain: ☐Consistent ☐Come and go

Does it interfere with your? ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other _____

Please check the following movements or activities that are painful for you to perform:

☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other _____

Circle the area(s) of complaint(s) and grade the intensity of pain in each area using 0–10 scale, with 10 being the highest level of pain.



ACCEPTANCE AS A PATIENT

I understand and agree that South West Health Professional Center (SWH) has the right to (1) accept or refuse me as a patient at any time before treatment begins, (2) terminate my care as a patient if in the course of treatment, I choose to not follow the treatment plan for my condition, or (3) be referred out to another health provider as the doctors deem medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of gathering information so that the doctors can determine whether to accept me as a patient.

AUTO ACCIDENT HISTORY (cont'd)

1. I was the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger
   a. What was your point of impact?
      ☐ Head On ☐ Rear End ☐ Left Front ☐ Left Rear ☐ Right Front ☐ Right Rear
   b. Did you feel pain immediately following the accident? ☐ Yes ☐ No
   c. If you answered no how long after the accident was it before the pain started? _____ Days
   d. Did you receive any of the following: ☐ X-Ray ☐ CT Scan ☐ MRI ☐ Lab Work
      ☐ Treatment/Meds ☐ None
   e. How did you get there? _____
   f. List any doctors you have seen prior to this first visit to our office, their specialty, and any treatments received: _____
      _____

2. Your Vehicle Type: _____
3. Second Vehicle Type: _____
4. Third Vehicle Type: _____
5. Road Conditions: _____
6. Road Type: _____
7. Were you aware the accident was going to occur? ☐ Yes ☐ No
8. Were you wearing a seatbelt? ☐ Yes ☐ No
9. Did your airbag deploy?
   ☐ Yes ☐ No
10. Does your car have a headrest?
    ☐ Yes ☐ No
11. What position was the headrest in?
    ☐ Up ☐ Middle ☐ Down
12. Head Position: _____
13. Were you pushing the brake (stopping) either during or before impact? ☐ Yes ☐ No
14. Was your car moving before impact? ☐ Yes ☐ No If yes, how fast? _____(mph)
15. Was the driver of the second vehicle braking (stopping)? ☐ Yes ☐ No
16. Was the second vehicle moving before impact? ☐ Yes ☐ No If yes, how fast? ____(mph)
17. Was the driver of the third vehicle braking (stopping)? ☐ Yes ☐ No
18. Was the third vehicle moving before impact? ☐ Yes ☐ No If yes, how fast?____(mph)
    If other area then describe: _____

COLLISION DETAILS (Describe how the cars collided. My vehicle was…)

19. First Impact: _____
    (My car was hit in the…) _____
20. Second Impact: _____
    (My car was hit in the…) _____

COLLISION RESULTS ("During the accident my…")

21. Body was thrown: _____
22. Head Hit: _____
23. Chest Hit: _____
24. Shoulders Hit: _____
25. Knees Hit: _____
26. Hips Hit: _____

VEHICLE DAMAGE

27. First Vehicle: _____
28. Second Vehicle: _____
29. Third Vehicle: _____

AUTO ACCIDENT HISTORY (cont'd)

PERSONAL INJURY

30. Were you hospitalized? ☐ Yes ☐ No
    a. How were you transported to the hospital? _____
    b. What did the hospital recommend? _____
    c. Did you have any x-ray, CT scans or MRIs taken? ☐ Yes ☐ No
       If yes, what areas? _____
31. List all of your symptoms/ complaints/ conditions here:

    _____

    _____

    _____
32. Describe the quality of your symptoms: _____
33. How would you describe your current symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness ☐ None ☐ Other _____

On a scale of 0 to 10, 0 being the lowest level and 10 being the heist, how would you rate the effect your condition or pain has:

34. On your daily functioning when you are at rest? _____
35. On your daily functioning when you are active? _____

36. When did this condition originally begin? ___/ ___/ ___
37. Is your condition currently…? ☐ Worsening ☐ Stagnant ☐ Lessening
38. If your condition has worsened or is worsening, when did the increased symptoms start?
    ___/ ___/ ___
39. When was the last time you experienced these symptoms? ___/ ___/ ___
40. Is your condition worse in the:
    ☐ Morning ☐ Afternoon ☐ Evening ☐ During Activity ☐ When resting
    and is it mostly: ☐Intermittent ☐ Constant ☐ Occasional ☐ None
41. Is your condition better in: ☐ Warm temp ☐ Cold temp ☐ Damp ☐ Sunny ☐ None
42. Is your condition worse in: ☐ Warm temp ☐ Cold temp ☐ Damp ☐ Sunny ☐ None
43. Check any of the following signs or symptoms that are associated with your current condition:
    ☐ Headache (Describe your headaches in detail): _____
    (Describe the location and type of sensation): _____
    ☐ Weakness (Describe the location): _____
    ☐ Other not Listed (Describe): _____
44. Do your symptoms seem to be better with:
    ☐ Activity ☐ Bending ☐ Cold ☐ Heat ☐ Massage ☐ Movement ☐ Rest ☐ Sitting
    ☐ Standing ☐ Standing ☐Stretching ☐ Twisting ☐ OTC Meds ☐ Prescription Meds
    ☐ Nothing

AUTO ACCIDENT HISTORY (cont'd)

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your

current health condition. Please give us information on those that apply to you.

45. Please list any medications or nutritional supplements that you are currently taking:

    _____

    _____

46. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided:

    _____

    _____

47. Childhood Illnesses (Please list any illnesses that you have had as a child):

    _____

    _____

48. Adult Illnesses (Please list any illnesses that you have had as a child):

    _____

    _____

49. Surgeries (Please list all surgical procedures that have had in the past):

    _____

    _____

50. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past):

    _____

    _____

51. Family History (Please list any genetic illness in your family):

    _____

    _____

52. Non Drug Allergies and how you react to those substances:

    _____

    _____

Daily Sports, Hobby, Travel, & School Activities Impaired (Loss of Enjoyment of Life)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*.

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident*.

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident*.

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Signature: _____ Date: _____

Daily Sports, Hobby, Travel, & School Activities Impaired (Loss of Enjoyment of Life)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident*.

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident*.

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was full time part time
- ☐ I am now full time part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

Signature: _____ Date: _____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____ _____

Signature Date

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

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.

One of the treatments that we may employ at South West Health Professional Center is spinal and or extremity manipulative therapy. Other treatments include, acupuncture with or without electric stimulation, instrument assisted soft tissue techniques, myofascial release, sports taping techniques, spinal decompression, massage therapy, electrical modalities, ice and moist heat, cupping, gua-sha, tui-na (Chinese manipulative therapy), infrared light, moxibustion, strength and conditioning exercises, activity advice ,Chinese herbal supplements and nutritional counseling.

Risks:

Chiropractic and acupuncture care are generally safe methods of treatment for certain conditions. As with any healthcare procedure, there are certain complications which may arise during sports chiropractic manipulative therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

Acupuncture may have some side effects including bruising, numbness, dizziness, and fainting. Unusual risks of acupuncture include infection and organ puncture. This facility utilizes sterile, disposable needles and maintains a clean and safe environment with a 0.0% incidence rate for both unusual risks. Burns and scarring are potential risks of moxibustion, infrared light and cupping. Petechiae (clusters of small red or purple spots) are an expected response to cupping and gua-sha.

We will make every reasonable effort during the examination to screen for contraindications to manipulative therapy and acupuncture to ensure that you are a candidate for treatment; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Strokes have been the subject of tremendous disagreement. The incidences of strokes are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter (OTC) analgesics and rest
- Medical care and prescription drugs such as NSAIDS, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE THEN, SIGN BELOW.

I have read or have had read to me the above explanation of the sports chiropractic adjustment, acupuncture and related treatment. I have discussed it with my attending sports chiropractor and acupuncturist and 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.

Dated: _____

Patient’s Name (print): _____

Patient’s Signature: _____

Doctor’s Name (print): _____

Doctor’s Signature: _____

Signature of Parent or Guardian (if a minor):_____

NOTICE OF DOCTOR'S LIEN

TO: Attorney _____

Address _____

_____

Phone _____

Joseph Zappala, DC, DACBSP®
Ren-Tsz Yeh, DC, LAc, DACBSP®
South West Health Chiropractic Center
2664 Newport Blvd,
Costa Mesa, CA 92627
949-631-5226

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical service rendered me by reason of this accident and by reason of any other bills that are due his/her 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 any 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 in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his/her 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. If this account is assigned for collection and/or suit, collection costs and/or interest, and /or attorneys fees, and/or court costs will be added to the total amount due.

Date: _____

Dated: _____ Patient's signature: _____

Witness: _____ Address: _____

Acknowledgement of Attorney

The undersigned being 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. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. (Under California State Insurance Code #10133).

Dated: _____ Attorney's Signature: _____

Attorney: Please date, sign and return one copy to above doctor's office at once.
Reply envelope attached.
Keep one copy for your records.