Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex_____ Marital Status_____ Date of Birth_____ Home Phone _____

Address_____ City_____ State_____ Zip _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. #_____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name_____ Spouse's Soc. Sec. #_____ Spouse's Employer_____ Location _____

Please explain in detail how your accident happened _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of injuries as you know them: _____

Did you require post accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach Upset	☐ Light Bothers Eyes	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Fainting	☐ Sleeping Problems	☐ Loss of Balance	☐ Back Pain
☐ Face Flushed	☐ Pins and Needles in Legs	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in Fingers	☐ Loss of Smell	☐ Fever
☐ Irritability	☐ Numbness in Toes	☐ Loss of Taste	☐ Chest Pain
☐ Cold Sweats	☐ Shortness of Breath	☐ _____	☐ _____

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any)

Name_____ Insurance Company_____ Policy No._____

Driver of vehicle in which you were injured (if applicable)

Name_____ Insurance Company_____ Policy No._____

Name of your insurance adjustor_____

Have you retained an attorney? ☐ Yes ☐ No

If so, his name and address_____

You were heading ☐ North ☐ East ☐ South ☐ West on _____(street or highway)

Other vehicle was heading ☐ North ☐ East ☐ South ☐ West on _____(street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long?_____

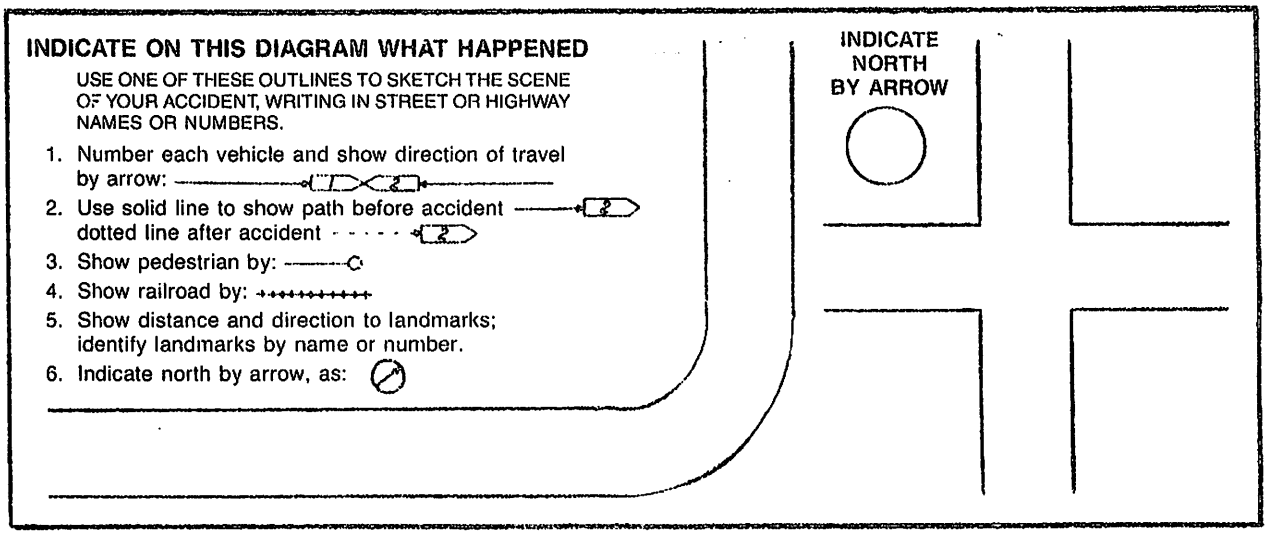
You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

INDICATE ON THIS DIAGRAM WHAT HAPPENED

USE ONE OF THESE OUTLINES TO SKETCH THE SCENE OF YOUR ACCIDENT, WRITING IN STREET OR HIGHWAY NAMES OR NUMBERS.

1. Number each vehicle and show direction of travel by arrow:
2. Use solid line to show path before accident
   dotted line after accident
3. Show pedestrian by:
4. Show railroad by:
5. Show distance and direction to landmarks; identify landmarks by name or number.
6. Indicate north by arrow, as:



I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 Chiropractic Office will be credited to my account on receipt. 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: _____

Guardian or Spouse's Signature:_____ Date_____

.....DO NOT WRITE BELOW THIS LINE.....

Patient accepted? ☐ Yes ☐ No Doctor's Signature_____

NEW YORK VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/01/02)

I, _____ , ("Assignor") hereby assign to O'Leary Chiropractic, DC, CCSP, ("Assignee") all right privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any prior written agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OF OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NO TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____
(Print name of patient) (Signature of the Patient)

_____
(Date of Signature)_

_____

_____
(Address)

_____ _____
(Print name of Provider) (Signature of Provider)

_____
(Date of Signature)

395 Bay Road
Queensbury, NY 12804
(Address)

NYS Form NF-AOB (3/2002)

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility
I have requested professional services from O'Leary Chiropractic ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

O'Leary Chiropractic, PLLC, is a HIPAA compliant office with regards to all personal health information (PHI). A HIPAA Privacy Policy informational packet is available to all patients. I have chosen to **Accept/Decline** this packet.

Date: _____ Name: _____

O'LEARY CHIROPRACTIC, P.L.L.C.

MICHAEL J. O'LEARY, D.C., C.C.S.P.
BRYAN M. STEELE, D.C.

395 Bay Road
Queensbury, NY 12804
Telephone: (518) 793-1205

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____ Best Contact #:_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height:_____ Weight:_____ Blood Pressure:_____/_____

BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25(3): 141-148.