InHealth PLLC
Sports Injury & Performance

InHealth, PLLC
Mechanism of Injury Questionnaire

PERSONAL INFORMATION

Name: _____ Date: _____

Street Address: _____

City/State/Zip: _____

E-Mail Address (required):_____

(H) Phone: (_____) _____ - _____ (W) Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Birth date: _____ / _____ / _____ Age: _____ Sex: M ____ F____

Name of Employer: _____ Occupation: _____

Marital Status: Single_____ Married _____ Domestic Partnership_____

Divorced _____ Widowed _____

Name of Spouse/Significant other (if applicable):_____

Name of Spouse/Significant other employer: _____

Work phone (_____) _____ - _____ Cell phone (_____) _____ - _____

Children: Yes ____ No ____ If yes, how many _____

Who referred you to our office: _____

Emergency Contact Information

Name: _____ Relationship: _____
Day Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Health Insurance

Name of insurance company: _____

Policy holder's name: _____ Policy number: _____

Employer: _____ SS#:_____

ACCIDENT INFORMATION

The following questions pertain to the other vehicle involved in the accident:

Name of Driver: _____ Phone #: _____
Address: _____ Ins. Company: _____
Agent's name: _____ Phone #: _____
Other Passengers Involved: _____

Date _____
Initials _____

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The following questions pertain to you:

Date of Collision: __、_____ Time: _____ **Place:** _____

Intersecting with: _____

Police Investigation by ☐ Washington State Patrol ☐ _____ City Police
☐ _____ County Police ☐ No investigation

Were there any witnesses? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No
If yes, whom? _____
Phone number ( ) _____-_____

Please describe, to the best of your knowledge, what happened during this collision.

_____

_____

_____

What is the last thing you remember before the collision? _____

What is the next thing you remember after the collision? _____

What type of car were you in? (year, make, and model) _____

What did your vehicle impact?
☐ Another vehicle (year, make, model) _____
☐ Other – explain _____

Road conditions at time of accident ☐ Wet ☐ Dry ☐ Icy ☐ Other – Describe_____
Where were you seated in the vehicle? ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Were you wearing a seat belt? ☐ Yes ☐ No
If yes, what type? ☐ Lap belt only ☐ Shoulder and lap belt

Did you have any bruising or tenderness on your body in the area of the seatbelt following the collision?
☐ Yes ☐ No If yes, please describe _____

Were you ☐ Aware of the approaching collision prior to impact
☐ Surprised by the impact

Was your vehicle equipped with headrests? ☐ Yes ☐ No
If yes, was the top of the headrest
☐ Above the base of your skull ☐ Below the base of your skull
Was the headrest altered or damaged in the collision? ☐ Yes ☐ No
Did your head go back over the top of the headrest? ☐ Yes ☐ No ☐ Unsure

Date _____
Initials _____

Is your car equipped with an air bag? ☐ Yes ☐ No
If yes, did the air bag activate? ☐ Yes ☐ No
If yes, did you receive any injury from the airbag? ☐ Yes ☐ No,
If yes, please describe _____

Did the impact to your vehicle come from the
☐ Front ☐ Rear ☐ Right side ☐ Left side ☐ Other _____

Was your car stopped at the time of impact? ☐ Yes ☐ No
If yes, was the driver's foot on the brake? ☐ Yes ☐ No ☐ Don't know
If your foot was on the brake, was it pressing down?
☐ Slightly ☐ Moderately ☐Strongly

If no, what was the approximate speed of your vehicle? _____mph

If your vehicle was moving at the time of impact, was it
☐ Slowing down ☐ Gaining speed ☐ Steady speed

Was your vehicle pushed forward from the impact? ☐ Yes ☐ No
If yes, how much?
☐ More than one car length ☐ One car length
☐ One-half car length ☐ Less than one-half car length
☐ Not at all

Did your car hit anything else after the first impact? ☐ Yes ☐ No
If yes, please describe _____

What is the cost of the damage to the vehicle you were in? _____

Which of the following car parts broke during the accident?
a. Windshield_____ d. Front seat back_____
b. Right/Left side window _____ e. Other _____
c. Steering wheel_____ f. Other _____

Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No
If yes, what was its approximate speed? Approximately _____ mph

If the other vehicle was moving at the time of collision, was it
☐ Slowing down ☐ Gaining speed ☐ Steady speed

What direction was your head pointed at the time of the collision?

☐ Right ☐ Left ☐ Forward

What was the position of your hands at the time of the collision?
_____

What was the position of your legs at the time of the collision?
_____

Date _____
Initials _____

Were you wearing a hat or eyeglasses at the time of the collision? ☐ Yes ☐ No
If yes, did they stay on? ☐ Yes ☐ No
If no, where did they land?

_____

What bruises or cuts did you get from this collision?

_____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
A. Head hit _____
B. Chest hit _____
C. Right shoulder hit_____ Left shoulder hit _____
D. Right arm hit _____ Left arm hit _____
E. Right hip hit _____ Left hip hit _____
F. Right leg hit _____ Left leg hit _____
G. Right knee hit _____ Left knee hit _____
H. Other: _____

When did you first notice pain or symptoms? _____

Please describe how you felt immediately after the collision.

_____
_____
_____

Did the collision render you unconscious? ☐ Yes ☐ No ☐ Don't know
If yes, for how long? _____

Have you gone to a hospital? ☐ Yes ☐ No Hospital _____
If yes, when did you go? _____
How did you get there? _____
What parts of your body were x-rayed? _____ ☐ None
What treatment did you receive? _____

Have you been treated by any other doctor or health professional? ☐ Yes ☐ No
If yes, Name: _____ City: _____
Recommendation and treatment received_____

How long were you treated? ☐ One time ☐ Other: _____

Have you taken any medications for your injuries? ☐ Yes ☐ No
If yes, what are you taking? _____
Are you still taking them? ☐ Yes ☐ No
Do they help? ☐ Yes ☐ No ☐ Don't know
If no, how long did you take them? _____
Why did you quit? _____

Have you lost time from work as a result of this injury? ☐ Yes ☐ No
If yes, give dates _____

Date _____
Initials _____

Are your work, home or recreational activities restricted as a result of this injury? ☐ Yes ☐ No
If yes, describe restrictions _____
_____

Indicate the symptoms that are a result of this collision

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Stomach upset	☐ Low back pain
☐ Headaches	☐ Fatigue	☐ Neck Stiffness	☐ Loss of balance
☐ Blurred vision	☐ Tension	☐ *Right* ☐ *Left*	☐ Leg pain
☐ Buzzing in ear	☐ Depression	☐ Mid back pain	☐ *Right* ☐ *Left*
☐ Ringing in ear	☐ Neck pain	☐ Chest pain	☐ Numb feet/toes
☐ Low back stiffness	☐ Numb hands/fingers	☐ Arms/shoulder pain	☐ *Right* ☐ *Left*

☐ Other: _____

Is your condition ☐ improved ☐ unchanged ☐ getting worse ☐ constant ☐ comes & goes

General Information

1. What is your primary complaint or reason for seeking care in our office? _____
   _____
2. How does your primary complaint interfere with your daily life or the activities you enjoy (i.e. work, exercise, getting dressed, social life, sleep, etc.)?
   _____
3. How would you best describe the symptoms you are experiencing? (i.e. burning, stabbing, numbness, tingling, dull ache, sharp, etc.) _____
   _____
4. How frequent is this condition?
   _____ < 25% of day
   _____ 26-50% of day
   _____ 51-75% of day
   _____ 76-100% of day
   _____ Only at night
5. How long does it last?
   _____ A few Seconds
   _____ A few minutes
   _____ All day
   _____ A few hours
   _____ All night
6. What makes it Better?
   _____
   _____
7. What makes it Worse?
   _____
   _____

Date _____
Initials _____

8. Have you had Chiropractic Care or Acupuncture before? If yes: when, where, with whom, and date of last visit:

_____

_____

9. Are there any other conditions or symptoms that may be related to your major symptom? If yes, what? _____

10. Have you ever been involved in an automobile collision or work related injury
Within the past year ____ Past 5 years ____ Over 5 years ____ Never ____

11. What significant health problems have you had in the past?

_____

_____

12. What significant accidents, falls, or injuries have you had in the past?

_____

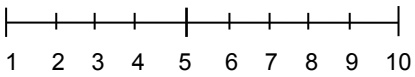
_____

Please list all surgeries you have had including date: _____

Your Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Medications	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Fruits/Vegetables	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Stress	☐	☐	☐	☐

Sleep Average Hours per night



Miscellaneous

Drugs or Medication(s) you take

☐ Sleeping Pills ☐ Antidepressants ☐Blood Pressure ☐ Cholesterol
☐ Birth Control ☐ Other: _____

Do you take nutritional Supplements? If so, please list

_____

Age of Mattress _____ ☐ Comfortable ☐ Uncomfortable

Are you wearing ☐ Heel Lift ☐ Sole Lifts ☐ Arch Support/Orthotic

Date _____
Initials _____

Allergies

Please list any allergies that you have, the nature of the reaction, and how long ago:

Health History

Please indicate for each of the questions below your experience by use of the following code: 1 = Presently have, 2 = Previously had

Musculo-Skeletal System

___Lower Back Problems	___Middle Back Pain	___Neck Problems
___Arm Problems	___Leg Problems	___Swollen Joints
___Painful Joints	___Stiff Joints	___Sore Muscles
___Weak Muscles	___Walking Problems	___Herniated Disk
___Hernia	___Broken Bones	___Teeth Grinding

Genito-Urinary System

___Bladder Trouble	___Excessive Urination	___Scanty Urination
___Painful Urination	___Discolored Urine	___Hard to Start Urination
___Testicular Pain	___Painful Ejaculation	___STD
___Kidney Stones	___Kidney Disease	___Urinary Tract Infection

Gastro-Intestinal System

___Poor Appetite	___Excessive Hunger	___Difficulty Swallowing
___Excessive Thirst	___Nausea	___Vomiting
___Abdominal Pain	___Diarrhea	___Constipation
___Bloody Stool	___Hemorrhoids	___Liver Trouble
___Gall Bladder Problems	___Weight Trouble	___Heart Burn

Nervous System

___Numbness	___Loss of Feeling	___Paralysis
___Dizziness	___Fainting	___Headaches
___Muscle Twitch/Spasm	___Concussion	___Depression
___Seizures	___Tingling in Hands	___Pain Down Legs/Arms

Eye, Ear, Nose, &Throat

___Vision Problems	___Eye Inflammation	___Ear Discharge
___Ear Pain	___Ear Ringing	___Hearing Loss
___Nose Pain	___Nose Bleeding	___Nose Discharge
___Sore Gums	___Dental Problems	___Sore Throat

Date _____
Initials _____

Female

___Vaginal Discharge	___Vaginal Bleeding	___Vaginal Pain
___Breast Pain	___Lumps on Breast	___Painful Menstruation

Cardiovascular & Respiratory Systems

___Chest Pain	___Difficulty Breathing	___Persistent Cough
___Coughing Blood	___Rapid Heartbeat	___Blood Pressure Problem
___Heart Problems	___Lung Problems	___Varicose Veins

Family History

Please circle all that apply:

Grandparents: Heart Disease - Cancer - Stroke - Diabetes - High blood pressure -
Other:_____

Father: Heart Disease - Cancer - Stroke - Diabetes - High blood pressure -
Other:_____

Mother: Heart Disease - Cancer - Stroke - Diabetes - High blood pressure -
Other:_____

Siblings: Heart Disease - Cancer - Stroke - Diabetes - High blood pressure -
Other:_____

Additional notes on family history:

_____
_____
_____

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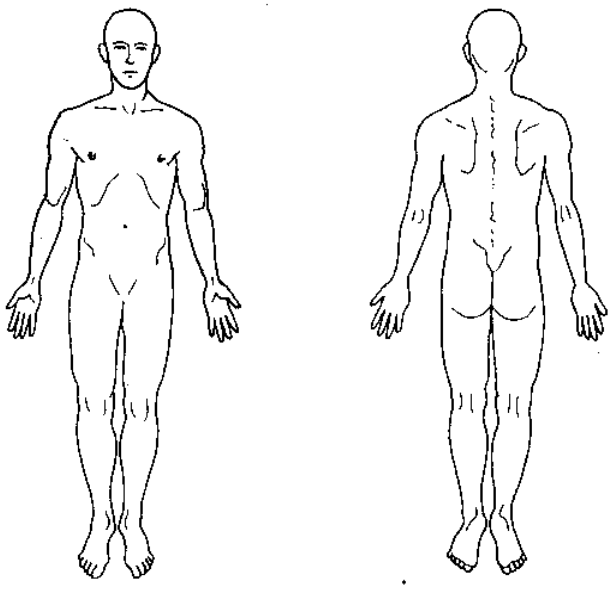
Symptom Pattern Diagram

Symptom Pattern Diagram

Please read carefully:

Mark the areas on your body where you feel your symptoms. Include all affected areas. Mark areas of radiation. If your symptom radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the symptom travel. Use the appropriate symbol(s) listed.

Ache:	**A**
Numbness:	**N**
Pins & Needles:	**PN**
Burning:	**B**
Stabbing:	**S**
Throbbing:	**T**
Other: _____	



Treatment

What Type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to find relief of the symptoms I am experiencing.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problem and then go on to ""performance and wellness care" to achieve my optimal level of health.

Please list any other treatment/health goals so that we can work together to best achieve your objective for seeking care at our office:

_____

_____

_____

Date _____
Initials _____

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Consent to Treatment – Children under the age of 18

I hereby give my consent to InHealth PLLC to examine and treat my child of ward.

Patient's Name: _____
Guardian's Signature: _____ Date: _____

Office & Financial Policies

*****PLEASE READ & SIGN*****

Right to Modify Terms
InHealth PLLC reserves the right to modify the terms of this Agreement at any time at its sole discretion, and may post a notice of such changes. If and when the Agreement is modified, You will be subject to the terms of the modified Agreement, and by seeking services at InHealth PLLC, You agree to the terms of modified Agreement, without further notice.

We at InHealth, PLLC strive to provide excellent patient services. In order to run our scheduling and billing efficiently, we have implemented the following policy. There is a fee for missed appointments if 24 hour advanced notice is not given, or if you are more than 15 minutes late to your appointment.

Chiropractic Appointments $45.00
Massage Appointments $45.00
Acupuncture Initial Appointments $75.00
Acupuncture Appointments $45.00

Financial Policy

Please present your health insurance card today. We will submit your claims on behalf to your health insurance company. Please note that healthcare and accident insurance policies are an arrangement between the carrier and the subscriber/patient, and the patient is personally responsible for all services rendered. Our office will prepare any necessary reports and forms to assist in making collections from the insurance companies. However please be aware that sometimes insurance companies deny claims for various reasons, we will resubmit such claims if denial is based in an error on our part. If claims are denied for any other reasons, we will then bill the patient directly and let the patient collect reimbursement from the insurance company. If your insurance plan requires a PCP referral, it is your responsibility to provide that to us. Our office will not verify nor will we check your insurances benefits; it will be your responsibility to check and verify your benefits.

Deductibles/Coinsurances/Copays: If your insurance plan requires a calendar/plan year deductible and it has not been satisfied at the time of service, payment will be collected from the patient on the day services are rendered. Unless prior arrangements have been with the billing coordinator, all copays and deductibles are due at the time service is rendered.

Time of Service Rate: Our time of service discount rate is available only when payment is received within two business days from the day the service was rendered. Time of service patients who do not make payment on the services are rendered will be billed the regular rate.

Date _____
Initials _____

Workers Compensation/Labor & Industries: You need to report your accident to your employer, bring in necessary documentation of the accident and insurance information (if applicable). Complete and sign accident report or the L&I Report of Industrial/Occupational Injury. **Until the claim is approved/denied you may be required to pay the acquired fees.**

Personal Injury: Please provide our office with the following information: **accident report, your car insurance policy information, the other party's insurance information, you attorney information, and the other party's attorney information (if applicable).** Until all of the necessary information is provided, you may be required to pay acquired fees. Patients with Personal Injury Protection (PIP) are not requires to pay all fees. **If InHealth PLLC files a Medical Lien for your case, you will be responsible for the fee required by the auditor's office to file the paperwork necessary to satisfy the lien.**

Ultimately you are fully responsible for any amount not paid my your insurance, even if your claim was denied. Neither InHealth, PLLC nor any of the Doctors, Therapists or staff can enter into any dispute with any insurance company and so it is your obligation and full responsibility to contact your health insurance and verify your eligibility and benefits. It is also your responsibility to see that your bill is paid.

By signing below, I permit InHealth, PLLC to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered are charged directly to my account and that I am personally responsible for payment. It is my understanding that if I suspend or terminate my care and treatment; any fees for professional services rendered will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors of InHealth, PLLC, and whomever they may designate as their assistants, to administer treatment as they so deem necessary. I also authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

I understand that the above information and statements made on this form are accurate to the best of my knowledge, and I understand it is my responsibility to inform the office of any future changes in medical status.

Patient Name: _____ Date: _____

Patient Signature: _____

Date _____
Initials _____