

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 _____

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension | <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Depression | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> |
| <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Numb feet/toes |
| <input type="checkbox"/> Low back stiffness | <input type="checkbox"/> Numb hands/fingers | <input type="checkbox"/> Arms/shoulder pain | <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> |
| <input type="checkbox"/> Other: _____ | | | |

Is your condition improved unchanged getting worse constant comes & goes

General Information

- What is your primary complaint or reason for seeking care in our office? _____

- 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.)?

- How would you best describe the symptoms you are experiencing? (i.e. burning, stabbing, numbness, tingling, dull ache, sharp, etc.) _____

- How frequent is this condition?

_____ < 25% of day
_____ 26-50% of day
_____ 51-75% of day
_____ 76-100% of day
_____ Only at night
- How long does it last?

_____ A few Seconds	_____ A few hours
_____ A few minutes	_____ All night
_____ All day	
- What makes it Better?

- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruits/Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fast Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Teeth Grinding |

Genito-Urinary System

- | | | |
|--|--|--|
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Scanty Urination |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Hard to Start Urination |
| <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Painful Ejaculation | <input type="checkbox"/> STD |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Urinary Tract Infection |

Gastro-Intestinal System

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Weight Trouble | <input type="checkbox"/> Heart Burn |

Nervous System

- | | | |
|--|--|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle Twitch/Spasm | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Pain Down Legs/Arms |

Eye, Ear, Nose, & Throat

- | | | |
|--|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Eye Inflammation | <input type="checkbox"/> Ear Discharge |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Nose Pain | <input type="checkbox"/> Nose Bleeding | <input type="checkbox"/> Nose Discharge |
| <input type="checkbox"/> Sore Gums | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Sore Throat |

Date _____

Initials _____

Female

- | | | |
|--|---|---|
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Vaginal Pain |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Lumps on Breast | <input type="checkbox"/> Painful Menstruation |

Cardiovascular & Respiratory Systems

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Blood Pressure Problem |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> 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:

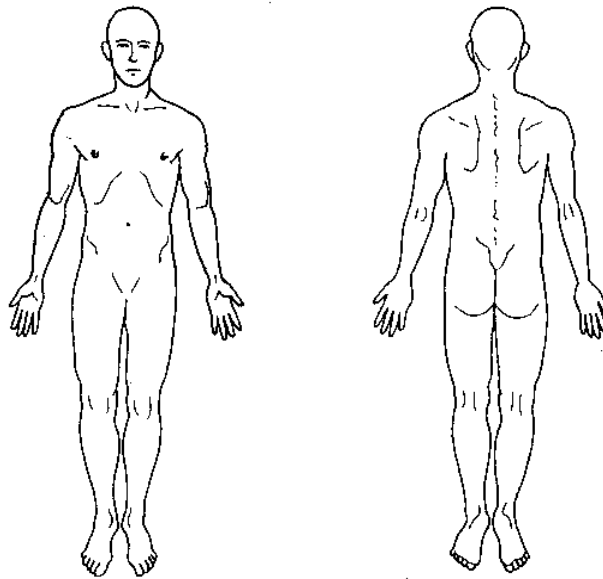
Symptom Pattern Diagram

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 starts 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 _____

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 _____