Accident History Form

Houk Chiropractic Clinic

Northpointe Office
9720 N. Nevada
Spokane, WA 99218
(509) 464-2273

Monroe Office
3809 N. Monroe
Spokane, WA 99205
(509) 326-3795

Patient Name: ______________________________ **Date:** ________________

Describe in detail how your symptoms began: __________________________
____
____
____
______________________________ **Date of Injury (DOI):** ______________

What was your pain level, prior to your injury/accident?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Complete the following if your condition is related to a Motor Vehicle Collision:

Where were you seated in the vehicle? (Circle One) Driver / Passenger / Backseat Left / Backseat Right
How was your vehicle hit? (Circle One) Head-On / Rear End / Broadside / T-Bone / Roll Over
What type of vehicle were you driving? ____
What type of vehicle was the other person driving? ________________________________
Were you aware of the impending collision? Y / N
Were you wearing your seat belt? (Circle One) Lap / Shoulder / Both / None
What was your estimated MPH @ time of impact? ____________________ Other Vehicle? _________________
What was your hand position on the steering wheel? _______________________________
What was you head position? (Circle One) Straight Ahead / Turned Left / Turned Right / Looked Behind
Was your headrest: (Circle One) Behind Head / Below Head (at neck) / Not Present
Left Foot Position? Clutch / Floor Right Foot Position? Brake / Gas / Floor
Did your body impact anything inside the vehicle? _________________________________
____
Did you remain conscious? Y / N: ____
Did the airbag deploy? Y / N Were the police involved? Y / N
How did you leave the scene of the collision? Ambulance / Drove / Picked Up
Did your seat break in the collision? Y / N

Please list all symptoms you have experienced following the motor vehicle collision:
1. ______________________ 2. ______________________ 3. ______________________
4. ______________________ 5. ______________________ 6. ______________________

Have you experienced any of the following after the motor vehicle collision?
1. Dizziness Y / N If Yes, for how long? ______________________________
2. Blurred vision Y / N If Yes, for how long? ______________________________
3. Ringing in the ears Y / N If Yes, for how long? ______________________________
4. Memory changes Y / N If Yes, for how long? ______________________________
5. Jaw Pain Y / N If Yes, for how long? ______________________________

For Office Use Only:

PATIENT CONDITION QUESTIONNAIRE (PCQ)

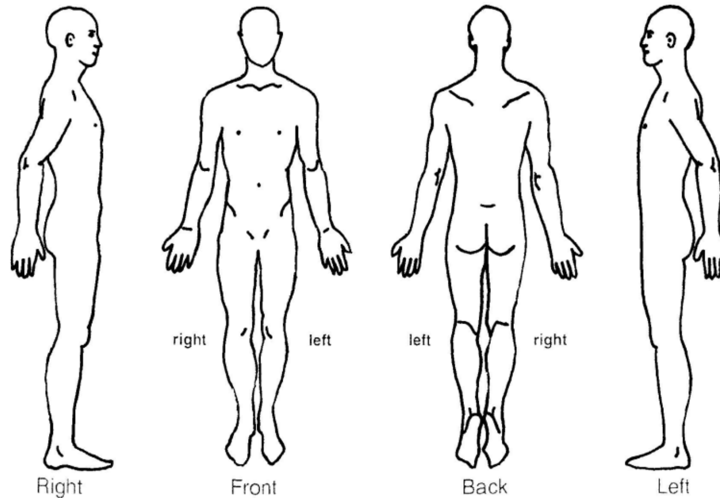
Name: ______________________ **Date:** ______________ **DOB:** ____________

1) Briefly describe the problem (s):

____
____
____
____

2) Please indicate the location of your pain/symptoms on the diagram below. Use the symbols to best describe the type(s) of pain/symptoms you have:

D= Dull Ache **N**= Numbness **T**= Tingling (Pins & Needles)
B= Burning **S**= Sharp **Z**= Stiffness / Tight



Additional Comments: ______________________
____
____

3) When did this condition / injury become a problem?

____

4) Have you had a similar episode(s) before?
□ No □ Yes, Date(s): ______________________

5) Have you seen any other healthcare providers for this condition? □ No □Yes
If yes, who did you see? ______________________
What was the diagnosis? ______________________
____

6) Have you had X-Rays, MRI, Etc. for this condition?
□ No □ Yes, Date: ______________________

7) Mark your average pain level on the line below.

____
Least Pain Worst Pain

8) Mark your pain level at its worst on the line below.

____
Least Pain Worst Pain

9) Please list your top 3 problem areas below and circle your frequency of pain/symptoms to the right of each one.

I) ________________ Seldom - Intermittently - Occasionally - Frequently - Constantly - Other: __________

II) ________________ Seldom - Intermittently - Occasionally - Frequently - Constantly - Other: __________

III) ________________ Seldom - Intermittently - Occasionally - Frequently - Constantly - Other: __________

10) Pain Better: □ a.m. □ mid-day □ p.m. □ at rest □ does not change □ other: ______________

11) Pain Worse: □ a.m. □ mid-day □ p.m. □ at rest □ does not change □ other: ______________

Acknowledgment of Financial Interest

To Our Patient:

It is important that our patients understand that payment for services provided by *Houk Chiropractic Clinic* **are the responsibility of the patient.** As a courtesy to you, we may bill your insurance company or, in some cases, agree to defer collection on your account until your claim is resolved. In order to ensure we receive payment, the patient agrees to the following:

I hereby authorize and direct my attorney or, if I do not have an attorney, any insurance representative making payment on my behalf, to pay directly to *Houk Chiropractic Clinic* all sums that are due and owing for all services rendered by reason of this accident as part of any settlement, verdict or compromise of claim.

I further agree that I am responsible for all charges for services provided by *Houk Chiropractic Clinic*, including any service charges on my account. Should it be necessary for *Houk Chiropractic Clinic* to take legal action to collect on my account, I agree that I am responsible for the costs of the action, including reasonable attorney fees.

This agreement is made solely for the protection of *Houk Chiropractic Clinic* in consideration of awaiting payment. I further understand that payment on my account is not contingent on receipt of any settlement, judgment or compromise of claim that I may receive.

____________________________ ______________ ________________

Print Patient Name | Date of Injury | Claim Number

____________________________ ____________________________

Patient / Parent / Guardian Signature | Today's Date

(Must be 18 or older to sign)

If signing on behalf of the patient, please state your relationship: ________________________

To the Insurance Company:

Our patient has authorized direct payment to *Houk Chiropractic Clinic* from any settlement, judgment or compromise of claim for services provided by us in relation to the above referenced accident. In addition to this agreement, it is our practice to file medical liens with the Spokane County Auditors office. **Pursuant to RCW 60.44, it is your obligation to protect our lien.** If you make payment on our patient's claim without protecting our lien, we will pursue the lien against you directly, including any costs and attorney fees incurred, as authorized by RCW 60.44.010.

To My Attorney:

The patient has authorized you to pay *Houk Chiropractic Clinic* directly for any balance remaining on his/her account at the time of resolution of his/her claim. Please acknowledge this agreement with your signature below. Please also honor this agreement at the time our patient's claim is resolved.

____________________________ ____________________________

Attorney Signature | Today's Date

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