

PERSONAL INJURY QUESTIONNAIRE

Name _____ Date _____ Patient ID # _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work _____ Cell _____

E-mail Address _____ Social Security # _____

Birthdate _____ Age _____ Sex M F Married/Single/Widowed/Divorced

Number of Children _____ Referred to this Office By _____

If a Minor (under 18 years old), name and address of responsible parent/guardian:

Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work _____ Cell _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact _____ Relationship _____

Home Phone _____ Work _____ Cell _____

EMPLOYMENT INFORMATION

Employer _____ Occupation/Title _____

Employer Address/Phone _____

City _____ State _____ ZIP _____

ATTORNEY INFORMATION

Name _____ Phone _____ Fax _____

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident _____ Time of Day _____

2. Were You: _____ Driver _____ Passenger _____ Front Seat _____ Back Seat

3. Number of people in your vehicle? _____ Were you wearing seat belts? _____ Yes _____ No

4. What direction were you headed? _____ North _____ East _____ South _____ West
on (name of street) _____

5. What direction was the other vehicle headed? _____ North _____ East _____ South _____ West

6. Were you struck from: _____ Behind _____ Front _____ Left side _____ Right side

7. Approximate speed of your car _____ mph Other car _____ mph

8. Were you knocked unconscious? _____ Yes _____ No If yes, for how long? _____

9. Were police notified? _____ Yes _____ No

10. In your own words, please describe the accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? _____ Yes _____ No

If yes, describe: _____

12. Please describe how you felt:
- a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____

13. Were you taken to the hospital after THIS accident? _____

14. What are your PRESENT complaints and symptoms? _____

15. Do you have any congenital (from birth) factors which relate to this problem? _____

16. Do you have any previous illnesses which relate to this case? ___ Yes ___ No
 If yes, please describe: _____

17. Have you ever been involved in an accident before? ___ Yes ___ No
 If yes, please describe: _____

18. Have you been treated by another doctor since the accident? ___ Yes ___ No
 If yes, names: _____

19. Since this injury occurred, are your symptoms: ___ Improving ___ Getting Worse ___ Same

20. CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

HEADACHE	IRRITABILITY	NUMBNESS-TOES	FACE FLUSHED	FEET COLD
NECK PAIN	CHEST PAIN	SHORTNESS-BREATH	BUZZING IN EARS	HANDS COLD
NECK STIFF	DIZZINESS	FATIGUE	LOSS OF BALANCE	STOMACH UPSET
SLEEPING PROBLEMS	HEAD IS HEAVY	DEPRESSION	FAINTING	CONSTIPATION
BACK PAIN	PIN/NEEDLES – ARMS	LIGHT SENSITIVE - EYE	LOSS OF SMELL	COLD SWEATS
NERVOUSNESS	PIN/NEEDLES – LEGS	LOSS OF MEMORY	LOSS OF TASTE	FEVER
TENSION	NUMBNESS – FINGERS	EARS RING	DIARRHEA	_____

Symptoms other than above: _____

21. Have you lost time from work as a result of this accident? ___ Yes ___ No

- a. Last day worked: _____
- b. Type of Employment: _____
- c. Present Salary; _____
- d. Are you being compensated for time lost from work? ___ Yes ___ No
 If yes, type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ___ Yes ___ No
 If yes, please describe: _____

23. Was there any damage to your car? ___ Yes ___ No

24. Other pertinent information: _____

25. If you are female, are you pregnant? ___ Yes ___ No

HEALTH HISTORY / TRAUMA

Please UNDERLINE conditions you have had PREVIOUSLY and CIRCLE conditions you have NOW

- | | | |
|-------------------------------|------------------------|---------------------------------|
| DIABETES | CANCER | HEART DISEASE |
| LOW BACK PAIN | PAIN BETWEEN SHOULDERS | NECK PAIN |
| ARM PAIN | JOINT PAIN/STIFFNESS | WALKING PROBLEMS |
| NUMBNESS | PARALYSIS | DIFFICULTY CHEWING/CLICKING JAW |
| DIZZINESS | FORGETFULNESS | CONFUSION/DEPRESSION |
| FAINTING | CONVULSIONS | COLD/TINGLING EXTREMITIES |
| ALLERGIES | LOSS OF SLEEP | FEVER |
| HEADACHES | SINUS TROUBLE | STOMACH/ DIGESTIVE PROBLEMS |
| ARE YOU PREGNANT? Y ___ N ___ | STROKE or ANEURYSM | HIGH BLOOD PRESSURE |

Previous injuries, trauma, or illness not listed above _____

Prior Surgeries

Date _____ Type _____
Date _____ Type _____
Date _____ Type _____

Current Medications

Name _____ Reason for taking _____
Name _____ Reason for taking _____
Name _____ Reason for taking _____
Name _____ Reason for taking _____
Name _____ Reason for taking _____

Social and Occupational History

Job description _____
Recreation Activities _____
Lifestyle (hobbies, exercise, alcohol, tobacco and drug use, and diet) _____

Family Health History

Health Problems of Immediate Family members (Cancer, Heart Disease, Stroke, Diabetes and High Blood Pressure)



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AUTO ACCIDENT / PERSONAL INJURY INSURANCE VERIFICATION

Name _____ Patient ID # _____ Date of Accident: _____

NOTE: When involved in an auto accident, medical claims are managed through each driver's own auto insurance. For example, if you are rear-ended and the accident is deemed entirely the other party's fault, any medical care provided to you as an injured party is still handled through your auto insurance policy.

If you are seeking medical care related to an auto accident, contact your auto insurance company and file a claim. Inform them that you are seeking medical attention related to the accident and write down the following information as your proof of insurance for the medical facility. It is against the law for your insurance company to raise your rates for filing a med-pay (personal injury) claim.

YOUR AUTO INSURANCE (MED PAY)

Name of Insured: _____ Policy #: _____

Insurance Company: _____ Claim #: _____

Insurance Company Address (where claims should be sent):

City _____ State _____ ZIP _____

Name of the Claims Adjuster assigned to your claim: _____

Claims Adjuster's Phone Number: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on January 1, 2007 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees,

conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may

have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposed of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment activities.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$ 0.10 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and healthcare operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Encompass Chiropractic Health
4309 Oakridge Road
Lake Oswego, OR 97035

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____



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Health and Medical Information Release Form

I, _____, give permission to Dr. Kris Pollack, his staff, associates, and employees of Encompass Chiropractic Health to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Pollack and his staff.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Information

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____