PATIENT INFORMATION

FULL name _____ Date _____

Please list any other names (e.g. maiden name) you have *ever* used:

Name	Dates Used
_____	_____
_____	_____

Address: _____ City_____ Zip _____

Phone (cell)_____(home)_____(work)_____

e-mail_____Fax_____

Date of Birth:_____SSN:_____Driver's License #:_____

Who Referred You To Our Office? _____

Was anyone else in the vehicle with you? _____

Marital Status: S M D W Spouse's Name:_____

Dependents and Ages:_____

Height_____ Weight:_____ L/R Handed?_____

Facts of the Collision

Date:_____ Time:_____ am/pm City\Location: _____

During the 24 hours before the collision, did you *or any other person involved* in the collision use or take any alcohol, prescription medication, or other drug? No Yes

If yes, who and what? _____

Please draw the location and direction of each vehicle involved:

Please describe how the incident happened:

_____

_____

_____

_____

Cost of repairing your car: $_____

Your Car Insurance Company:_____

Address:_____

Adjustor:_____

Phone:_____Claim Number_____

What are your Medical Payments Policy Limits on your own car insurance ? _____

What are you Uninsured/Underinsured Policy Limits on your own car insurance? _____

Was a Police Report Made ? Yes No Which Police Department?_____

Medical History After This Collision

If you were taken in an Ambulance, please give us this information

Ambulance Company _____

Where did they take you? _____ Ambulance Bill $ _____

If you were in any Hospital after this collision, please give us this information

Hospital #1_____ City _____

Did you stay overnight? Yes No How many days were you in the hospital? _____

Hospital #2_____ City _____

Did you stay overnight? Yes No How many days were you in the hospital? _____

For any other Doctor, Dentist, Physical Therapist, Acupuncturist, etc. since this collision, please give:

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Dentist #1_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Dentist #2_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Dentist #3_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Medical History Before This Collision

Have you EVER had any Motor Vehicle Accidents, Workers Compensation Claims, or other claims of Injury of ANY type? Yes No If yes, when? _____

Who is your regular doctor? Name:_____

Address:_____ City _____ Zip _____

Phone:_____ Fax _____

List all doctors you have seen in your lifetime for any reason other than this collision:

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #1_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #2_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #3_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #4_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #5_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

Doctor/Chiropractor/Acupuncturist/Physical Therapist/Hospital #6_____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Reason _____

(Please use the back of this page if there are more Doctors/Hospitals etc. you have seen)

Employment

Employer at Time of Collision:_____

Address:_____ City _____ ZIP _____

Job Title:_____ Job Duties:_____

Have you missed any time from work because of this collision? Yes No When? _____

Were you on duty at work when this accident occurred? Yes No In what capacity? _____

Additional Information the Doctor should know about you and this collision:

_____

_____

_____

_____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

Household & Domestic: Duties Under Duress & Loss of Enjoyment

Patient _____ Date of Accident _____

Describe how the accident has affected your household duties outside the home (i.e. Mowing, gardening, yardwork, house painting, transporting family, shopping, taking out trash etc.) And your domestic duties inside the home (i.e. Vacuuming, cooking, picking up children, caring for children, dusting, cleaning bathrooms, laundry, washing windows/mirrors, etc.)

Duty _____

- ☐ I can only do this _____ minutes at a time since the accident
- ☐ I have been limited because I had trouble ☐ lifting ☐ bending ☐ standing ☐ walking
- ☐ I have had to take ☐ prescription ☐ over-the-counter medications to do this
- ☐ I had to do this because ☐ I have no other help ☐ because I care for the children
- ☐ I have experienced the following problems when I do this activity:
  - ☐ Range of motion/movements restricted in my body
  - ☐ Pain in my _____
  - ☐ Headaches ☐ Muscle Spasms ☐ Dizziness ☐ Visual Disturbance
  - ☐ Sleep Disruption/Tired/Fatigue/Dozing of/Must rest for a while
  - ☐ Radiating pain into my _____
  - ☐ Anxiety or depression ☐ TMJ/jaw pain or clicking
  - ☐ It has taken me longer to do this activity than before the accident

Duty _____

- ☐ I have been able to do this _____ minutes at a time since the accident
- ☐ I have been limited because I had trouble ☐ lifting ☐ bending ☐ standing ☐ walking
- ☐ I have had to take ☐ prescription ☐ over-the-counter medications to do this
- ☐ I had to do this because ☐ I have no other help ☐ because I care for the children
- ☐ I have experienced the following problems when I do this activity:
  - ☐ Range of motion/movements restricted in my body
  - ☐ Pain in my _____
  - ☐ Headaches ☐ Muscle Spasms ☐ Dizziness ☐ Visual Disturbance
  - ☐ Sleep Disruption/Tired/Fatigue/Dozing of/Must rest for a while
  - ☐ Radiating pain into my _____
  - ☐ Anxiety or depression ☐ TMJ/jaw pain or clicking
  - ☐ It has taken me longer to do this activity than before the accident

Duty _____

- ☐ I can only do this _____ minutes at a time since the accident
- ☐ I have been limited because I had trouble ☐ lifting ☐ bending ☐ standing ☐ walking
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  - ☐ Pain in my _____
  - ☐ Headaches ☐ Muscle Spasms ☐ Dizziness ☐ Visual Disturbance
  - ☐ Sleep Disruption/Tired/Fatigue/Dozing of/Must rest for a while
  - ☐ Radiating pain into my _____
  - ☐ Anxiety or depression ☐ TMJ/jaw pain or clicking
  - ☐ It takes me longer to do this activity than before the accident

_____ _____

Signature of patient Date completed

THE EPWORTH SLEEPINESS SCALE

Patient _____ DOI _____ Today's Date _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

The Rivermead Post-Concussion Symptoms Questionnaire*

Patient _____ DOI: _____ Today's Date _____

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to *compare yourself now with before the accident*. For each one please circle the number closest to your answer.

0=Not experienced at all
1=no more of a problem now than before the accident
2=a mild problem now
3=a moderate problem now
4=a severe problem now

Compared with before the accident, do you now (i.e. over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light sensitivity, or easily upset or irritated by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?
Please specify, and rate as above.

1_____	0	1	2	3	4
2._____	0	1	2	3	4

*King, N., Crawford S., Wenden F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Dr. Poff

NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENT'S SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATED ATTORNEY SIGNATURE

INTEGRATED WELLNESS CENTERS

21520 S. Pioneer Blvd., Suite 210
Hawaiian Gardens, CA 90716
Telephone: (562) 809-0351
Fax: (562) 809-0372

NOTICE OF PRIVACY PARCTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information, I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information Is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by such restrictions.

Patient Name_____

Patient Representative_____

Signature X_____

Date_____

Dear Patient,

We all have occasional problems with getting to an appointment for one reason or another, we understand that and want to be able to be as flexible as possible for you.

We also know that an appointment canceled at the last minute is an appointment that another patient will not be able to utilize. We now have a policy that if you ***fail to give 24 hours notice*** of canceling or rescheduling your appointment time you will be charged with a $25 fee for the missed appointment.

Please note: We normally do not enforce this policy unless someone is being a so-called "repeat offender." In other words we will be flexible, we just want you to respect our schedule and the other patients treatment plans.

If you need to move an appointment from one time to the next we can usually accommodate that even if it is last minute, please just call us and give us notice so we can do everything we can to keep everyone on track.

Please feel free to ask any questions if your not clear on this contract.

Thank you for your understanding,

Management at Integrated Wellness Centers

Patient Signature _____ Date _____

INTEGRATED WELLNESS CENTERS

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Hawaiian Gardens, CA 90716
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Patient Name_____

Patient Representative_____

Signature X_____

Date_____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he/she may designate as

Assistants to administer treatment as deemed necessary to my (Circle one) son or daughter,

Name_____ Date _____

Parent or Guardian signature _____