PERSONAL INJURY (MVA)

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

Today's Date: _____

Last Name:		MI: First Name:	
Home Address:		City: State: Zip:	
Date Birth:	Age:	Occupation:	
Height:	Weight:	Marital Status (Circle): Single, Married, Divorced, Widowed	
Home Phone:		Social Security Number:	
Work Phone:		Cell Number:	
Email Address:			

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have medical payment insurance for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate the name of the person that the policy is under:
How is this person related to you?	☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: Telephone (area code):
Claim Number:	
Do you have an Insurance Deductible?	☐ Yes, ☐ No Deductible is: $
Do you know your Policy Limits for medical bills?	☐ Yes, ☐ No Limit is: $
Have you reported this injury to your insurance carrier?	☐ Yes, ☐ No

☐ Yes, ☐ No. Do you have an attorney representing you? If yes, indicate name, address and telephone of your retained attorney:	Attorney Name: _____ Address: _____ Telephone:

√	I authorize said Doctor to release medical information necessary to process this claim to the above insurance carrier.
√	A photocopy of this authorization shall be considered as valid as the original.
√	I authorize direct payment of medical benefits to the undersigned doctor for services/procedures or supplies described in the billing statement or CMS-1500 form. I authorize said Doctor to use my name in the "Signature on File" in future billings.
√	I authorize use of this form on all my insurance submissions (billings).

You are ultimately responsible for any charges incurred in this office and will be **"balance Billed"** for any amount the insurance carrier(s) does not pay (Excess Payments). It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. **IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT CO-PAYMENT OR DEDUCTIBLE PAYMENT AT THE CONCLUSION OF EACH TREATMENT. OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES AS A COURTESY. ANY OUTSTANDING BALANCE CAN BE SUBJECT TO AN 18% ANNUALLY OR 1 ½ % PER MONTH INTEREST.**

Patient Signature Date:	I acknowledge that I am ultimately responsible for all charges that are incurred at the doctor's office. I agree to pay for any outstanding bills (including Excess Payments) incurred in this office, as well as paying for co-insurance or deductibles.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 160, 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** This notice explains how my protected health information (PHI) may be used and what their office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

Patient Signature and Date	By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall.

Patient Name: _____ Date: _____

GENERAL HEALTH HISTORY (Page 1)

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Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	☐	☐
☐	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	History of any disease such as AIDS, Tuberculosis, Meningitis, etc.?	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	☐	☐
☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or any disease affecting nerves/brain?	☐	☐
☐	Cancer history or cancer treatment of any type?	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)?	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused/abnormal vertebrae?	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?	☐	☐
☐	Have you ever been hospitalized? Why/When:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	☐	☐
☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	☐	☐
☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

☐ **NO. (Check box if you have no prior history of previous injury or pain)** If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

☐ **NO. (Check box if you have never had any broken bones in the past).** If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?

☐ **NO. (Check box if you never had any surgical procedure).** If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Patient Name: _____ Date: _____

GENERAL HEALTH HISTORY (Page 2)

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☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe:____

_____

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City: _____ Year:_____
List Problem(s) that the Chiropractor treated you for:_____

☐ No, ☐ Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, chest/breast surgery, port, etc? If yes, why: _____

MEDICATIONS (PRESCRIBED AND OVER-THE-COUNTER)

☐ No, ☐ Yes **Are you taking any medications currently.** In yes, list all medications that you are taking:

HERBS, VITAMINS, AND OTHER SUPPLEMENTS

☐ No, ☐ Yes **Are you taking any currently.** In yes, list all that you are taking:

LIST PHYSICAL ACTIVITIES THAT INCREASE/DECREASE YOUR SYMPTOMS?

Which physical activities or motions **increase or aggravate** your pain or symptoms?

Which physical activities or motions **lessen or relieve** your pain or symptoms?

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Since the injury did your pain and other symptoms come on? ☐ Suddenly, ☐ Gradually

CURRENT PAIN SEVERITY

Overall, how severe is your pain today (zero to ten level):
What number represents the most severe pain that you had today (0 to 10):
What number represents the least severe pain that you had today (0 to 10):
How frequent are you having pain today (percentage of time):

Patient Name: _____ Date: _____

NECK, MIDDLE BACK, AND EXTREMITY QUESTIONNAIRE

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Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question.

YES	NO	NECK REGION
☐	☐	Does neck and head movement cause your neck pain to intensify?
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
☐	☐	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____min/hrs)
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders?
☐	☐	Do you feel your neck pain sending pain downwards to the front of your chest?
☐	☐	Have you noticed your head leaning or tilting to one side recently?
☐	☐	Have you ever been diagnosed as having a disc bulge or disc herniation in your neck previously?
☐	☐	Does your neck make a "clunk" or other unusual sound when you move it?

YES	NO	SHOULDER, ARM, HAND, OR FINGER REGION
☐	☐	Do you have pain in your shoulder(s)? If yes, describe where:
☐	☐	Does arm motion make your shoulder pain worse? Describe:
☐	☐	Do you have pain, numbness, or tingling in your upper arm, elbow, forearm, or hand? Circle areas
☐	☐	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
☐	☐	Do you get increased arm numbness when lying flat on your back or sleeping on your side?
☐	☐	Does changing your sitting posture increase your arm/hand symptom intensity?
☐	☐	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
☐	☐	If you have arm/hand symptoms, do they improve when you lift your arms over your head?
☐	☐	If you have arm/hand symptoms, do they worsen when you lift your arms over your head?
☐	☐	If you have hand or arm pain at night, does it help to shake and massage them?
☐	☐	Do your hands feel tender when you grasp objects?
☐	☐	Do you feel weakness in your grip strength or do you drop objects from your hand?
☐	☐	Do you have difficulty writing or doing small motions with your fingers recently?
☐	☐	Do your hand(s) or wrist swell?
☐	☐	Recently, have your fingers or hands been cold or burning? Describe:
☐	☐	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?

YES	NO	MIDDLE BACK AND CHEST WALL REGION
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
☐	☐	When you move your neck around, does your middle back pain or chest pain increase?
☐	☐	Have you been diagnosed as having angina before?
☐	☐	Do you have a tight band-like feeling sometimes around your chest?
☐	☐	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	Does your middle back pain mostly bother you during sleep?

Patient Name: _____ Date: _____

LOW BACK, HIP, LEG AND FOOT QUESTIONNAIRE

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Check any of the following that intensify your low back pain and/or leg symptoms:

☐	Sitting	☐	Bending forward	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backward	☐	Lying on your back	☐	Putting on shoes

Check any of the following that lessen/improve your low back pain and/or leg symptoms:

☐	Sitting	☐	Bending forwards	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backwards	☐	Lying on your back	☐	Putting on shoes

Check all locations of any current leg pain, numbness, or tingling:

☐	Hip	☐	Buttock	☐	Back of thigh	☐	Calf
☐	Groin area	☐	Knee	☐	Front of thigh	☐	Foot/toes

YES	NO	***Check all areas with a yes or no (Skip if you are unclear about question)***
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Do you have a lot of leg cramps at night recently?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you observed that your low back pain is not relieved or made worse by any type of body motion?
☐	☐	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
☐	☐	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
☐	☐	Have you ever had an injection of Chymopapain into your discs (Spine) in your back or neck?
☐	☐	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
☐	☐	Does one or both of your legs feel weak recently?
☐	☐	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
☐	☐	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
☐	☐	If you have radiating leg or foot pain did you notice your leg symptoms before the low back pain started?
☐	☐	If you have leg pain, is your pain primarily focused in front of your thigh(s)?
☐	☐	Has your anal-rectal region been completely numb?
☐	☐	Do you have any recent prostate, ovarian, or uterine problems?
☐	☐	Have you ever had abdominal surgery, chest surgery, reconstructive surgery or other conditions in your past where your doctor has recommended that you should be careful when twisting or lifting?
☐	☐	Other:

YES	NO	**SLEEPING PATTERNS**
☐	☐	Do you sleep poorly at night?
☐	☐	Do you sleep on your stomach?
☐	☐	Do you consistently feel extremely tired when you wake up in the morning?

Patient Name: _____ Date: _____

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

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PATIENT NAME: _____ DATE: _____

***PATIENT INSTRUCTIONS**: Look at each symptom listed in the left column and **make a single check mark or several check marks in the appropriate columns** to the right for the specific symptoms which apply to you relative to the onset and current complaints.*

SYMPTOM LIST (Check all of the symptoms that began after your injury that apply to you)	**BEGAN IN LESS THAN 24 HOURS AFTER INJURY**	**SYMPTOMS BEGAN 1 TO 7 DAYS AFTER INJURY**	**YOU HAVE SYMPTOMS PRESENTLY**	**YOU HAD SIMILAR SYMPTOMS WITHIN 12-MONTHS PRIOR TO THIS INJURY**
Headache/migraine since injury				
Nausea and/or vomiting				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Dizziness or giddiness				
Feel unsteady when dark at night-time				
Balance problems standing or moving about				
Loss of coordination with arms/hands/legs				
Feel unsteady on feet walking or getting-up				
Misjudges distance when moving about				
Feel unsteady bending down to pick-up items				
Tripping while walking since injury				
Light-headed when turning head-looking up				
Lack of smooth arm/hand motion				
Sensitivity to light or sound				
Fatigue since injury				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm/hand pain/tingling/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				

Patient Name: _____ Date: _____

MOTOR VEHICLE CRASH FORM (Page 1)

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Office: (559) 230-1102 Fax: (559) 230-1105

Patient Name:_____ Date: _____

Date of crash:_____ Time of collision: _____ ☐ AM ☐ PM

City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry

Street (location) where crash occurred: _____

Who owns the vehicle in which you were hit? _____

What is the estimated repair damage to your vehicle? $_____ ☐ Unknown, ☐ Estimate not done yet

How many people were in your vehicle at the time of the crash? _____

☐ Yes, ☐ No Did the police come to the crash scene?

☐ Yes, ☐ No Did the police make a written report? If yes, our office would like a copy of the report.

☐ Yes, ☐ No Were any photographs taken of the vehicles? If yes, who took them?

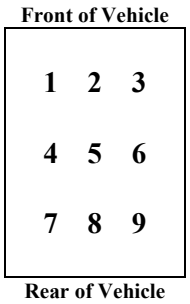
DESCRIBE HOW THE CRASH HAPPENED (Please print clearly)

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

☐	Single-vehicle crash	☐	Two-vehicle crash	☐	Three-or-more vehicles
☐	Rear-end crash	☐	Side crash	☐	Rollover
☐	Head-on or frontal crash	☐	Hit guard rail, tree, or object	☐	Ran off the road
☐	Other (Describe):				

CIRCLE YOUR SEATING POSITION (The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.



DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: ☐ Unknow

Patient Name: _____ Date: _____

MOTOR VEHICLE CRASH FORM (Page 2)

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AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐	Slowing down	☐	Gaining Speed	☐	Unknown speed
☐	Stopped	☐	Moving at steady speed	☐	Other:

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐	Slowing down	☐	Gaining Speed	☐	Unknown speed
☐	Stopped	☐	Moving at steady speed	☐	Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object/curb other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE CRASH:

☐	Windshield	☐	Seat bent or damaged	☐	Dash or area around knee/foot
☐	Steering wheel	☐	Side or rear window broken	☐	Other
Describe Damage:					

YES	NO	**CHECK BOXES BELOW**
☐	☐	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
☐	☐	Did you strike or did any objects or animals within your vehicle hit you during the crash?
☐	☐	Was the door(s) of your vehicle damaged to a point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes, circle (side airbag/front airbag)
☐	☐	Did you have any cuts, bruises, or abrasions from the airbag deploying?
☐	☐	Did your seatbelt system require repairs after the crash?
☐	☐	Was the back of your seat that your were sitting in damaged or bent during the crash?
☐	☐	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

Patient Name: _____ Date: _____

MOTOR VEHICLE CRASH FORM (Page 3)

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YES	NO	**SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:**
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap and Shoulder Strap, ☐ Automatic shoulder strap with driver needing to manually attach lap belt, ☐ Lap belt only
☐	☐	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
☐	☐	Did you have any cuts, bruises, or abrasions from the seatbelts?
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned ***(Use time clock face as your reference point)*** Left hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere Right hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint
☐ Fixed, non-moveable head restraint
☐ No headrests in my vehicle
☐ Bench seat in your vehicle without a head restraint
☐ Unknown

Please indicate how your <u>head restraint</u> was positioned at the time of crash (if present):

☐ At the top of the back of your head
☐ Midway height of the back of your head
☐ Lower height of the back of your head
☐ Located at the level of your neck
☐ Level of your shoulder blades
☐ Unknown

YES	NO	**DID YOU HAVE BRUISING AFTER THE CRASH?**
☐	☐	If yes, indicate where the (visibly black, red, and/or blue discolored areas) bruising areas were or is currently located on your body and what caused the bruising (if known, example seat belt or steering column):

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending crash and relaxed before the collision.
☐	You were aware of the impending crash and braced yourself.
☐	Your body, torso, and head were facing straight ahead.
☐	You had your head and/or torso turned at the time of collision: ☐ Turned to left, ☐ Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU *FIRST* NOTICE ANY PAIN/SORENESS/STIFFNESS AFTER THE CRASH?
(Examples: immediately or in minutes/hours/days) _____

Patient Name: _____ Date: _____

EMERGENCY ROOM, DISABILITY, & TREATMENT (Page 4)

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YES	NO	
☐	☐	Did you go to the emergency room afterward? If no, go to the bottom of this form and fill out the disability/treatment sections. If yes, indicate when date and time:_____ Name of the emergency room? City:
☐	☐	Did you go to emergency room in an ambulance?
☐	☐	Did you or another person drive you to emergency room? Name of other person:
☐	☐	Were you hospitalized after being seen in the Emergency Room? If yes, how many days:
☐	☐	Did the emergency room doctor take X-Rays? Check what regions x-rays were taken: ☐ Skull/Face x-rays ☐ Rib/Chest x-rays ☐ Neck or Middle back x-rays ☐ Collar bone x-rays ☐ Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand x-rays ☐ Leg or Foot ☐ Other
☐	☐	Did the hospital or clinic take MRI or CT of your body? If yes, indicate what areas of body: ☐ Skull, ☐ Neck, ☐ Low back or hip/pelvis, ☐ Other
☐	☐	Did you have any broken bones/fractures? If yes, where:
☐	☐	Did you have a splint or cast put on for any sprain or fracture? If yes, type/location:
☐	☐	Did you have any dislocations? If yes, where:
☐	☐	Did you have any cuts, lacerations, or abrasions? If yes, where:
☐	☐	Did you require any stitching for cuts? If yes, where:
☐	☐	Did you have any visible bruises or lumps? If yes, where:
☐	☐	Did you have any visible bruises along the shoulder or lap portions of your seatbelt?
☐	☐	Did the emergency room doctor give you pain medications or muscle relaxants?
☐	☐	Did the emergency room doctor give you any other medications/prescriptions?
☐	☐	Did you require any surgery after the accident? If yes, describe type and date:
☐	☐	Were you hospitalized overnight? If yes, indicate dates hospitalized:

What did the Emergency Room or Hospital Doctor(s) say was wrong with you?

DISABILITY-HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ **YES,** ☐ **NO I have lost days (time) off work?** If yes, you were off work: ☐ Partially ☐ Completely

Please list all dates off work: From _____ to _____.

If yes, what physical activities (sitting, bending, lifting, walking, etc) have limited your ability to work?

CURRENT TREATMENT

☐ YES, ☐ NO Are you currently seeing any doctor/therapist? If yes, who: _____

☐ YES, ☐ NO Are you currently using any type of brace, support, collar, cane, crutches, TENS unit, or other devices to help your pain since the injury? If yes, indicate what type and how often you use: _____

☐ YES, ☐ NO Are you currently taking any over-the-counter or prescribed medications to help your pain? If yes, list these medications and how often you take them: _____

☐ YES, ☐ NO Have you been treating yourself (ice, heat, lotions, etc.)? If yes, list: _____

Patient Name: _____ Date: _____

PROVIDERS SEEN SINCE THE COLLISION (Page 5)

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

Start with the first hospital/clinic/doctor/therapist that you went to after your motor vehicle crash and list all health care providers (all types of doctors or therapists), up to your last health care provider seen, and check all that apply for each. Be certain to list these in sequence from first health care provider seen to the last.

① Name Emergency Room, hospital/doctor/therapist/center: _____

Address:_____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/ pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arms/legs	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse=

② Name hospital/doctor/therapist/center seen: _____

Address:_____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arm/leg	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests: _____	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

③ Name of hospital/doctor/therapist/center: _____

Address:_____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arm/leg	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests: _____	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

Patient Name: _____ Date: _____

MOTOR VEHICLE COLLISION GENERAL PRECAUTIONS

Hokokian Chiropractic
1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

Patient Name: _____ Date: _____

Strong and very rapid forces may be involved in your automobile accident. It is important that you watch for any new symptoms that might be a sign of hidden injury. It is normal to feel soreness, pain, and tightness in your body, often getting worse the second or third days. However, more severe pain and new symptoms such as numbness, tingling, balance issues, and weakness in your arms and legs should be reported to your doctor.

As a result of a motor vehicle collision, some people feel a general sense of stress or anxiety which can lead to trouble sleeping or irritability. Some people feel like avoiding driving in vehicles for some time. In the majority of cases, these feelings go away within a few days or weeks.

AVOID NEW INJURIES

It is important for the first week to two weeks to avoid any high-risk activities that may re-injure you.

HOME CARE

Your doctor will be giving you advise about how important it is to keep active during the healing process. Getting an extra 30 minutes to one-hour of extra sleep a night is recommended for the first week. Make certain to get restful sleep. It is important to comply with the home recommendations that the doctor gives you. If using ice, for example, be certain to use a thin towel between the ice pack and your skin and keep the ice on for the prescribed length of time. If the doctor recommends walking every day for a prescribed period of time and you develop significant pain or difficulty please stop and notify the doctor at your next visit.

GOALS

The primary goal in this office is to restore your ability to return to your normal activities of daily living, including work, home, and recreational activities. It is very important that you let your doctor know if you have or develop any problems with muscle weakness, endurance, coordination, balance, and overall ability to move your body in a coordinated manner. If deficiencies are noted by the doctor, then a program will be developed for you to do in home, gym, or at the doctor's office depending upon the type and severity of the conditions.

FOLLOW-UP APPOINTMENTS

It is important that you keep your appointments and follow all home instructions.

CALL OUR OFFICE PROMPTLY

Be certain to call your doctor promptly at (phone) if any of the following occur:

- New and unusually intense headache, balance, or visual symptoms
- Repeated vomiting, dizziness, vertigo, or fainting
- New or worsening pain
- Confusion or change in behavior or speech
- Weakness in your arms or legs
- New neurological symptoms

Patient Name: _____ Date: _____

INFORMED CONSENT

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient names below, for whom I am legally responsible) by **John H. Hokokian, DC,** and/or other licensed doctors of the chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **John H. Hokokian, DC,** whether or not their names are listed on this form.

I understand and consent to the following procedures (checked below):

☐ Examination ☐ Mobilization ☐ Ultrasound ☐ Muscle Stimulation
☐ X-rays ☐ Traction ☐ Adjustments

I have had an opportunity to discuss with **John H. Hokokian, DC,** the various types of treatment, including neck and spinal/extremity adjustments that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT) _____DATE:_____

X_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

(If signing for a MINOR)
NAME: _____RELATIONSHIP:_____

OFFICE/WITNESS SIGNATURE: _____ DATE:_____

PATIENT INSTRUCTION AND AUTHORIZATION TO PERSONAL INJURY INSURANCE CARRIER TO MAKE DIRECT PAYMENT TO CHIROPRACTOR

I , hereby authorize and instruct the following insurance carrier _____ to send (mail) all paid monies for diagnostic testing, treatment, and/or medical supplies to the following Doctor/Office (see below) for all services/supplies billed:

SEND AND MAKE ALL PAYMENT CHECKS PAYABLE TO:

Dr. John H. Hokokian, D.C.
HOKOKIAN CHIROPRACTIC
1543 W. Shaw Avenue Fresno, CA 93711
Tax I.D. 77-0336039

√	I authorize said Doctor to release any information pertinent to my case to the mentioned insurance carrier.
√	A photocopy of this authorization shall be considered as valid as the original.
√	I authorize said Doctor to use my name in the "Signature on File" in future billings.
√	I authorize direct payment to above Doctor.
√	I authorize use of this form on all my insurance submissions (billing).

LIMITED POWER OF ATTORNEY FOR PAYMENT OF CHIROPRACTIC BILLS

I hereby, give limited Power of Attorney, for said Doctor/ Clinic, to cash and deposit any sums paid by the above insurance carrier for only the specific injury indicated on this form.

Today's Date:

Patient Name (Please Print):

Signature of Parent (Policyholder):

Signature of Patient/ Guardian, if other than policyholder:

Date of Injury:

Witness Signature:

Patient Name: _____ Date: _____