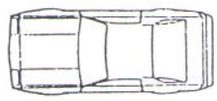
LA Chiro Spa & Holistic Center
Dana Zappala, D.C.
818.707.4488
www.lachirospa.com

Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____
   Year & Model of the other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark
   ☐ other (describe): _____
10. Where was your car struck?

FRONT  REAR

In your own words, please describe accident: _____

_____

_____

11. Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact
    ☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
13. Did you see the accident coming? ☐ yes ☐ no
14. Did you brace for impact? ☐ yes ☐ no
15. Were seatbelts worn? ☐ yes ☐ no
16. Were shoulder harnesses worn? ☐ yes ☐ no
17. Does your car have headrests? ☐ yes ☐ no
18. If yes, what was the position of those headrests compared to your head before the accident? ☐ Top of headrest even with **bottom** of head
    ☐ Top of headrest even with **top** of head
    ☐ Top of headrest even with **middle** of neck
19. Was your car braking? ☐ yes ☐ no
20. Was your car moving at the time of the accident? ☐ yes ☐ no
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
    ☐ Head turned left/right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right/left
    ☐ Head straight forward ☐ Other:
24. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock
    ☐ Dazed, circumstances vague ☐ Other:
25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or glasses? ☐ yes ☐ no
27. Could you move all parts of your body? ☐ yes ☐ no

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28. If no, what parts couldn't you move and why?

_____

29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
32. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
33. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
34. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid back pain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping problems	☐ Numbness in fingers
☐ Numbness in toes	☐ Loss of smell	☐ Loss of taste
☐ Loss of memory	☐ Fatigue	☐ Breath shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of balance	☐ Tension	☐ Cold hands
☐ Cold feet	☐ Diarrhea	☐ Constipation
☐ Chest pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other _____	

_____

35. Occupation: _____
36. Employer: _____
37. Have you missed time from work: ☐ yes ☐ no
38. If yes, full time off work: _____ to _____
39. If yes, part time off work: _____ to _____
40. Did you seek medical help immediately after the accident? ☐ yes ☐ no
41. If yes, how did you get there? ☐ Ambulance ☐ Police
    ☐ Someone else drove me ☐ Drove own car ☐ Other: _____
42. Doctor #1: Name: _____
43. First Visit Date: _____
44. Were you examined? ☐ yes ☐ no
45. Were X-rays taken? ☐ yes ☐ no
46. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars
47. If yes, what kind of treatment did you receive? _____
48. What benefits did you receive from the treatment? _____
49. Date of last treatment: _____
50. Doctor #2: Name: _____
51. First Visit Date: _____
52. Were you examined? ☐ yes ☐ no
53. Were X-rays taken? ☐ yes ☐ no
54. Did you receive treatment? ☐ yes ☐ no
55. If yes, what kind of treatment did you receive? _____

56. What benefits did you receive from the treatment?_____
57. Date of last treatment:_____
58. Do you have an attorney on this claim? ☐ yes ☐ no
59. If yes, who?_____
Address_____
City_____ State_____ Zip_____ Phone_____

Illustrate below how the accident happened

Past Medical History: Place an (X) if it applies and describe.
☐ None related to current complaints ☐ Hospital or operation
☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other
Describe_____

Family History: Place an (X) if any family member has suffered from:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Allergy	☐ Arthritis
☐ Hypertension	☐ Cancer	☐ Migraines
	☐ Heart Attack	☐ Other, list:_____

Personal History: Place an (X) if it applies, describe.
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower
Number of Children_____ Number of Children at home_____

Employed Spouse ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no ☐ not sure

Medications, describe_____

Disease, describe_____

Other, describe_____

SYSTEM REVIEW Place an (X) next to the symptoms you know you have

Genito-Urinary System

- ☐ Bladder trouble
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Discolored urine
- ☐ Scanty urination

Gastro-Intestinal System

- ☐ Poor appetite
- ☐ Difficult swallowing
- ☐ Vomiting food
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight trouble
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Abdominal pain
- ☐ Black stool
- ☐ Liver trouble
- ☐ Difficult chewing
- ☐ Nausea
- ☐ Diarrhea
- ☐ Bloody stool
- ☐ Gall bladder trouble

Nervous System

- ☐ Numbness
- ☐ Dizziness
- ☐ Muscle jerking
- ☐ Confusion
- ☐ Loss of feeling
- ☐ Fainting
- ☐ Convulsions
- ☐ Depression
- ☐ Paralysis
- ☐ Headaches
- ☐ Forgetfulness

Cardio-Vascular System

- ☐ Chest pain
- ☐ Persistent Cough
- ☐ Rapid heartbeat
- ☐ Lung problems
- ☐ Pain over heart
- ☐ Coughing phlegm
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Difficult breathing
- ☐ Coughing blood
- ☐ Heart problems
- ☐ Other

Eye, Ear, Nose and Throat System

- ☐ Eye strain
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nose discharge
- ☐ Sore mouth
- ☐ Speech difficulty
- ☐ Eye inflammation
- ☐ Ear noises
- ☐ Nose pain
- ☐ Breathing difficulty
- ☐ Sore throat
- ☐ Dental problems
- ☐ Vision problems
- ☐ Ear discharge
- ☐ Nose bleeding
- ☐ Sore gums
- ☐ Hoarseness

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1 PAIN INTENSITY

- ☐ I can tolerate the pain I have without using painkillers.
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers give no relief from pain and I do not use them.

SECTION 2 PERSONAL CARE (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 WALKING

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 SOCIAL LIFE

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

SECTION 10 TRAVELING

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain restricts me to the journeys of less than one hour.
☐ Pain restricts me to short necessary trips under a 1/2 hour.
☐ Pain restricts me from traveling except to the doctor or hospital.

Current Chief Complaint(s): Place an (X) in the appropriate complaint areas.

Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back ☐ Mid back ☐ Neck
☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L ☐ Arm R/L ☐ Elbow R/L
☐ Wrist R/L ☐ Forearm R/L ☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L ☐ Thigh R/L ☐ Knee R/L
☐ Leg R/L ☐ Ankle R/L ☐ Foot R/L

OTHER (describe): _____

_____

_____

Subjective Pain Level:

On a scale of 1 - 10 place an (X) in your current pain level

NORMAL
☐ 0

LOW PAIN
☐ 1 ☐ 2 ☐ 3

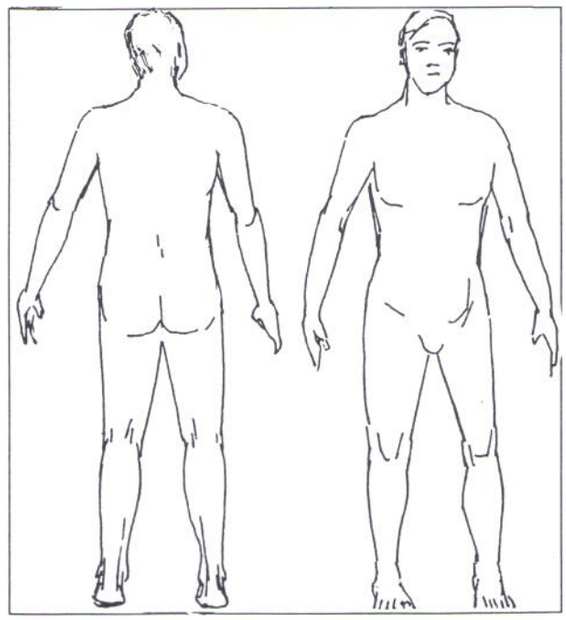
MODERATE PAIN
☐ 4 ☐ 5 ☐ 6

INTENSE PAIN
☐ 7 ☐ 8 ☐ 9

EMERGENCY
☐ 10

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X NUMBNESS + BURNING
○ PIN & NEEDLES = STABBING



_____
Patient's Signature

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

NCC-CA

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Guardian/Parent/Representative) (Provide name and relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

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