AUTO COVER SHEET

Patient's Full Name: ____

Patient's Street Address: ____

City, State, Zip: _______________________, _______, ____________________

Phone #: (_____) _____ - ___________ Date of Injury: ______/______/_________

Police Report on File? ____ YES _____ NO

INSURANCE TYPES: (check all that apply) ____ P.I.P. ____ Med Pay ____ 3rd Party

____ Attorney ____ Health Insurance ____ Accident/Disability ____ W.C.

****L.O.P. (Letter of Protection) from attorney on file? ____ YES ____ NO**

__________ INSURANCE: Name of Ins. Co.: ______________________________
(PIP, Med?)

Phone# of Ins. Co.: (_____) _______ - __________ ext. ________

Address of Ins. Co.: ____________________________________

City, State, Zip: _____________________, _____, _____________

Claim #: _________________________ Adjuster: _______________________

__________ INSURANCE: Name of Ins. Co.: ______________________________
(PIP, Med?)

Phone# of Ins. Co.: (_____) _______ - __________ ext. ________

Address of Ins. Co.: ____________________________________

City, State, Zip: _____________________, _____, _____________

Claim #: _________________________ Adjuster: _______________________

More Info:

>Insurance forms completed and signed? ___ YES ___ NO
(Such as Application for Benefits of PIP or Med-Pay, Attending Physican's Report.)
>Insurance forms completed and signed to the 3rd Party for the patient? ___YES ___NO

REPORTS WRITTEN BY US IN FILE:

_______Initial _______ Progress ______ Narrative ______ Radiology

INSURANCE COVER SHEET

Patient's Full Name: ____

Patient's Street Address: ____

City, State, Zip: _________________________, _______, ______________________

Phone #: (_____) _____ - ___________ Date of Injury: ______/______/__________

INSURANCE TYPES: (check all that apply) ____ Primary ____ Secondary ____ Tertiary

____ Accident/Disability

__________ INSURANCE: Name of Ins. Co.: ________________________________
(Primary)

Phone# of Ins. Co.: (_____) _______ - __________ ext. ________

Address of Ins. Co.: _______________________________________

City, State, Zip: ______________________, _____, _____________

Policy #: __________________________ Group #: ________________________

__________ INSURANCE: Name of Ins. Co.: ________________________________
(Secondary)

Phone# of Ins. Co.: (_____) _______ - __________ ext. ________

Address of Ins. Co.: _______________________________________

City, State, Zip: ______________________, _____, _____________

Policy #: __________________________ Group #: ________________________

More Info:

>Ins. Co. in Computer? _____ Initials
>Insurance Verified? _____ Initials
>Explained to Patient? _____ Initials
>Info Billed to Ins. Co.? _____ Initials

Co-Pay or % ______________________

Other Notes: ____

____

____

PATIENT NARRATIVE STATEMENT

In your own words, please describe (in detail) the physical, emotional, and mental effects the accident you suffered has had on your work/school activities and your daily living activities:

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Patient Signature: ____________________________________ Date: _____/______/_______

AUTO ACCIDENT FORM

Patient Name: ___________________________________ **Today's Date:** _____/_____/______

Please mark your involvement in the Auto Accident: [ ] Pedestrian [ ] Driver [ ] Passenger

What are your current symptoms? [ ] Pain [ ] Numbness [ ] Stiffness [ ] Weakness

Date of Accident: _____/_____/______

Patient was located: [ ] Driver [ ] Passenger – Middle Front [ ] Passenger – Right Front

[ ] Passenger – Left Rear [ ] Passenger – Middle Rear [ ] Passenger – Right Rear

Patient Vehicle Type: [ ] Compact [ ] Mid-Size [ ] Full-Size [ ] SUV [ ] Pick-Up [ ] Motorcycle

Second Vehicle Type: [ ] Compact [ ] Mid-Size [ ] Full-Size [ ] SUV [ ] Pick-Up [ ] Motorcycle

Third Vehicle Type: [ ] Compact [ ] Mid-Size [ ] Full-Size [ ] SUV [ ] Pick-Up [ ] Motorcycle

Road Conditions: [ ] Clear [ ] Dark [ ] Dry [ ] Foggy [ ] Icy [ ] Wet

Road Type: [ ] Asphalt [ ] Concrete [ ] Dirt [ ] Gravel

Were you aware the accident was going to occur? [ ] YES [ ] NO

Were you wearing a seatbelt? [ ] YES [ ] NO

Did your airbag deploy? [ ] YES [ ] NO

Does your car have a head rest? [ ] YES [ ] NO

What position was the head rest in?[ ] Up [ ] Middle [ ] Down

Patient's Head Position: [ ] Looking straight ahead [ ] Looking Up [ ] Looking Down
[ ] Left Level [ ] Left Up [ ] Left Down
[ ] Right Level [ ] Right Up [ ] Right Down

Accident Details

Was your car breaking? [ ]Yes [ ]No **Was your car moving?** [ ]Yes [ ] No
If yes, how fast? (mph) [ ]<5 [ ]6-10 [ ]11-15 [ ]16-20 [ ]21-30 [ ]31-40 [ ]41-50 [ ]51-60 [ ]61-70 [ ]>70

Was the second vehicle breaking? [ ]Yes [ ]No **Was the second vehicle moving?** [ ]Yes [ ] No
If yes, how fast? (mph) [ ]<5 [ ]6-10 [ ]11-15 [ ]16-20 [ ]21-30 [ ]31-40 [ ]41-50 [ ]51-60 [ ]61-70 [ ]>70

Was the third vehicle breaking? [ ]Yes [ ]No **Was the third vehicle moving?** [ ]Yes [ ] No
If yes, how fast? (mph) [ ]<5 [ ]6-10 [ ]11-15 [ ]16-20 [ ]21-30 [ ]31-40 [ ]41-50 [ ]51-60 [ ]61-70 [ ]>70

Collision Details

First Impact: [ ] Hit by other vehicle [ ] Hit other vehicle [ ] Hit by object [ ] Hit Object

Impact Location: [ ] Front [ ] Front-Right [ ]Front – Left [ ] Left [ ] Right
[ ] Right – Rear[ ] Left – Rear [ ] Rear[ ] Top

Second Impact: [ ] Hit by other vehicle [ ] Hit other vehicle [ ] Hit by object [ ] Hit Object

Impact Location: [ ] Front [ ] Front-Right [ ]Front – Left [ ] Left [ ] Right

[ ] Right – Rear[ ] Left – Rear [ ] Rear[ ] Top

Collision Results

Body was thrown: [ ]Forward [ ]Backward [ ]Left [ ] Right [ ] Can't Remember

Head Hit: [ ] Airbag [ ] Front Windshield [ ] Rearview Mirror [ ] Steering Wheel
[ ] Dashboard [ ] Back of the front seat [ ] Side window/door
[ ] Another person's body [ ] Headrest

Chest Hit: [ ] Airbag [ ] Steering Wheel [ ] Dashboard [ ] Back of the front seat
[ ] Side window/door [ ] Another person's body

Shoulders Hit: [ ] Shoulder harness [ ] Side window/door [ ] Back of front seat
[ ] Another person's body

Knees Hit: [ ] Steering wheel [ ] Dashboard [ ] Back of the front seat
[ ] Door panel [ ] Center Console [ ] Another person's body

Hips Hit: [ ] Steering wheel [ ] Dashboard [ ] Back of the front seat
[ ] Door panel [ ] Center Console [ ] Another person's body

Vehicle Damage

Patient Vehicle: [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage
Second Vehicle: [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage
Third Vehicle: [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage

Hospitalized

Were you hospitalized? [ ] YES [ ] NO If YES, please answer the questions below.

When were you hospitalized? [ ] Immediately [ ] Later Same Day
[ ] Next Day [ ] Date____/____/______

How were you transported to the hospital? [ ] Ambulance [ ] Life Flight [ ] Private Transport

What did the hospital recommend? [ ] No Instructions [ ] See this Clinic [ ] See DC
[ ] See own Doctor [ ] See Orthopedist [ ] See Neurologist [ ] Prescription Medication
[ ] Other: ____

Did you have X-Rays Taken? [ ] YES [ ] NO If yes, what areas? __________________________

Modifying Factors:

Symptoms better with: [ ] Nothing Helps [ ] Activity [ ] Bending [ ] Applying Cold [ ] Rest
[ ] Applying Heat [ ] Massage [ ] Movement [ ] OTC Meds [ ] Rx Meds
[ ] Stretching [ ] Sitting [ ] Standing [ ] Twisting [ ] Walking

Symptoms Worse with: (as noted in Social History)

>**Since condition began, has anything permanently helped you?** [ ] YES [ ] NO

>**Has anything that you have done, thus far, fixed your problem?** [ ] YES [ ] NO

Employment:

Occupation/Job Title: ____________________________________ Work: ______ hrs/ day or week

Description of Work: ____

Job Classification: [ ] Sedentary (<5lbs) [ ] Light (5-20lbs) [ ] Moderate (20-50lbs) [ ] Heavy (>50lbs)

Lifting Frequency: [ ] Constant(67-100%/day) [ ] Frequent(33-66%/day) [ ] Occasional(0-32%/day)

Lifting Postures: [ ] With Arms [ ] High Near [ ] From Knee [ ] Off Posture [ ] From Torso

Work Activity Postures: (hrs/day)
[ ] Bending: ____h/d [ ] Climbing: ____h/d [ ] Kneeling: ____h/d [ ] Pulling: ____h/d [ ] Pushing: ____h/d
[ ] Reaching: ____h/d [ ] Sitting: ____h/d [ ] Standing: ____h/d [ ] Twisting: ____h/d [ ] Walking: ____h/d

Repetitive Activities: (hrs/day)
[ ] Assembly/Fine Manipulation: ____h/d [ ] Computer Use/Typing: ____h/d [ ] Grasping: ____h/d
[ ] Hand Tool Use: ____h/d [ ] Operation of Machinery Controls: ____h/d [ ] Phone Use: ____h/d

Condition's Effect on Job Performance:

[ ] **Mild – Painful** (Can Do) [ ] **Moderate – Painful** (Limited Ability) [ ]**Mod/Sev** Limited Duty
[ ] **Severe –** No Limited Duty [ ] **Severe –** Can't Do Limited Duty

Daily Activities: Effects of Current Condition on Performance:

Bending:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Care – Infirm Family:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Carrying Groceries:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Change Posn-Sit-Stand:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Climb Stairs:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Driving:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Extended Computer Use:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Feeding:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Household Chores:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Kneeling:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Lift Children:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Lifting:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Pet Care:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Reading (Concentration):	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Self Care:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Self Care-Bathing:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Self Care-Dressing:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Self Care-Shaving:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Sexual Activities:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Sleep:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Static Sitting:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Static Standing:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Walking:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
Yard Work:	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance:

______________________	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
______________________	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform
______________________	[ ] **No Effect**	[ ] **Mild** Painful (can do)	[ ] **Mod** Painful (limited)	[ ] **Sev** Unable to Perform

Chief Complaint – HPI (History of Present Illness)

Patient Name: ____________________________________ **Date:** ____/____/______ **Dr.:** ______________

Chief Complaint: ____

Body Area(s) Involved: [ ] Cervical [ ] Spine, Ribs, Pelvis [ ] Upper extremity [ ] Lower Extremity

Condition: [ ] New -> [ ] Acute or [ ] Chronic
[ ] Recurrence (Acute) [ ] Exacerbation (Acute) [ ] Chronic

Mechanism of Onset:

[ ] Auto: [ ] Driver/Passenger [ ] Pedestrian (refer to completed auto accident history form)
[ ] Work Related: [ ] Fall [ ] Falling Object [ ] Lifting [ ] Overexertion [ ] Repetitive Motion [ ] Other: _______
[ ] Other – Liability: [ ] Slip or Fall [ ] Other: ____
[ ] Other – No Liability: [ ] Etiology Unknown [ ] Overexertion [ ] Repetitive Use [ ] Slept Wrong [ ] Slip/Fall
[ ] No Injury

Description of Onset of Complaint: ____

Current Symptoms: [ ] Pain [ ] Numbness [ ] Stiffness [ ] Weakness

Location: Left / Right / Bilateral

Quality: [ ] Burning [ ] Diffuse [ ] Dull/Aching [ ]Localized [ ] Radiating [ ] Sharp
[ ] Shooting [ ] Stabbing [ ] Throbbing [ ] Tightness [ ] Tingling [ ] Other: ___________

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: ___________________ Last Occurred: ____________________
Last Episode: __________________ Resolved Previous Visit: __________________
Worsened: ___________________ Injury Occurred: _______________ Accident Occurred: ____________

Timing: Worse: [ ] Morning [ ] Afternoon [ ] Night [ ] With Activity [ ] Constant [ ] Intermittent

Context: *Better With:* [ ] Warm Temp [ ] Cold Temp
Worse With: [ ] Warm Temp [ ] Cold Temp [ ] Damp

Assoc Signs & Symptoms: [ ] Blurred Vision [ ] Depression [ ] Dizziness [ ] Irrability/Mood Swing
[ ] Localized Tingling [ ] Nausea [ ] Ringing in Ears [ ] Sleep Disturbance [ ] Stiffness

Headaches: Location: [ ] Occipital [ ] Frontal [ ] Left Temporal [ ] Right Temporal [ ] Sinus [ ] Parietal
Quality: [ ] Dull [ ] Sharp [ ] Throbbing [ ] Stabbing [ ] Aura [ ] No Aura
Types: [ ] Hat Band [ ] Cluster [ ] Migraine [ ] Tension
Other: (frequency/duration/time of day) ____

Radiation: Left / Right / Bilateral ____

Weakness: Left / Right / Bilateral ____

Other Assoc Signs & Symptoms:

[ ] Aches [ ] Burning [ ] Cold Limb(s) [ ] Difficulty Walking [ ] Dizziness
[ ] Eccymosis [ ] Chronic Fatigue [ ] Fever [ ] Heartburn [ ] Joint Stiffness
[ ] Muscle Spasm [ ] Muscle Weakness [ ] Nausea [ ] Numbness [ ] Pale Blush Skin
[ ] Panic [ ] Pins & Needles [ ] Rhinorrhea (runny nose) [ ] Shortness of Breath
[ ] Sweating [ ] Swelling [ ] Tingling [ ] Vomiting

IRROVACBLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE OF LIEN INTEREST

(Not a Statutory Lien)

Re: Medical Reports and Lien for ____.

I do hereby authorize **HILL COUNTRY FAMILY CHIROPRACTIC, DR. JEFFREY HARPER, D.C.**, who is my treating doctor and hereafter "the treating facility", to furnish my attorney and/or the insurance carrier, with a complete report of any medical examination, treatment, prognosis, etc. (including notes, x-rays, and other medical data, as determined necessary by my treating doctor), relating to my health care treatment in regard to the automobile accident or other contributing incident giving rise to my need for such health care services

ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST

I hereby execute and provide this **Irrevocable Lien Interest and Assignment of Proceeds** in favor of the above named doctor and/or the doctor's designated treating facility. This **Irrevocable Lien Interest and Assignment of Proceeds** shall apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am to paid in the form of an insurance settlement(s), claim(s), judgments(s), or verdict(s) resulting from the above identified accident (collectively the "insurance proceeds").

The Insurance Carrier is instructed that pursuant to this **Irrevocable Lien Interest and Assignment of Proceeds** the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility.

As consideration for my execution of this **Irrevocable Lien Interest and Assignment of Proceeds** I represent that said doctor and/or treating facility has provided me professional services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for this forbearance of his legal right to require payment by me at the time such services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this **Irrevocable Lien Interest and Assignment of Proceeds** shall apply to all insurance proceeds to which I am entitled and direct that the amount of such proceeds required to satisfy my outstanding balance with said doctor and/or treating facility be remitted directly to the doctor and/or treating facility, at such time as I receive an insurance settlement or other monetary settlement/award.

In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocable instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this agreement is made solely for the benefit of the doctor and treating facility, as additional protection and in consideration of the treating facility's agreement to forgo immediate collection of payment for such services rendered.

SIGNED ____ DATE: _____/_____/_______

Printed Name of Patient: ____

For or On Behalf of the Minor Child: ___________________________________, I do hereby assume full financial responsibility.

SIGNED ____ DATE: _____/_____/___

Relationship to Minor Child: ____