Welcome to

Chiropractic Works Health Center

Dr. Kenneth R. Weil,
1715 Howell Mill Road, C-12
Atlanta, Georgia 30318
www.AtlantaChiro.com
(404) 350-8000

"We specialize in automobile accident injuries"

We have two very important goals in regards to your automobile accident:

1. To help you recover from your injuries in as short a time as possible so that you can resume your life as before the accident, by providing you with exceptional chiropractic care.
2. To provide proper documentation and care that is specific to your individual needs.

To help us serve you better, it is necessary for you to answer all of the following questions to the best of your ability. If you have any questions, please ask a staff member for help before proceeding to the next question. We recognize that the questionnaire is long, however every question is important for us to provide you with outstanding care as well as to properly document all information for insurance purposes. Thank you for the opportunity to serve your chiropractic needs.

AUTO INJURY PATIENT QUESTIONNAIRE

TODAY'S DATE _____

FIRST NAME _____ M.I._____ LAST NAME _____

SEX (M/F) _____DATE OF BIRTH _____ SOCIAL SECURITY # _____

MARITAL STATUS - S M W D

ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ PHONE CARRIER_____

WORK NAME _____ WORK ADDRESS _____

WORK PHONE # _____ IMMEDIATE SUPERVISOR _____

WHAT TYPE OF WORK DO YOU DO? _____

EMAIL ADDRESS: _____

NAME OF SPOUSE _____SPOUSE BIRTHDATE_____

REFERRED BY: _____

DATE OF INJURY/ACCIDENT (required) _____

IN YOUR OWN WORDS, DESCRIBE THE ACCIDENT

_____

_____

_____

_____

_____

_____

What was your position in the vehicle? _____ driver _____ front passenger _____ rear left passenger _____ rear right passenger

Other _____

What type of vehicle were you driving? _____

What speed were you traveling at time of the accident? _____mph

Who hit you? ____ I was struck by another vehicle ____ I hit another vehicle ____ I hit a stationary object

Where was your vehicle hit? _____ What type of vehicle hit you? _____

What speed was the other vehicle traveling? _____mph What part of the other vehicle hit you? _____

Were you wearing seatbelts? Y/N ____ Full shoulder and lap belt? ____ Lap belt only? ____ Shoulder strap only?

Position of headrest ____behind head ____behind neck ____behind shoulders ____ No headrest

Position of head ____straight forward ____turned right ____turned left; Looking ____ up _____down

Position of hands ____on steering wheel ____other, please describe _____

Position of body ____sitting upright ____turned ____other; please describe _____

How many people were in your vehicle? _____ Please give the names of any others in your vehicle _____

_____

Were there any others injured in your vehicle? ____Y/N Who? _____

Were there any casualties in this accident? ____ Y/N Who? _____

How much damage was done to your vehicle? _____0 - 500$ _____ 500 – 1000$ _____ More than 1000$

Did your airbag deploy? ____ Y/N

Were you prepared for the impact? ____ Y/N

____ I was completely surprised ____ I saw the collision coming ____ I saw the collision coming and braced appropriately

What position was your body in just prior to the accident? _____

What happened to your body at the moment of impact? _____

Please describe how you felt physically - during the accident: _____

_____

Immediately after the accident: _____The next day: _____

Presently: _____

What was your mental/emotional state immediately after the accident? _____

Did you receive medical attention at the scene of the accident? _____Y/N Where did you go after the accident? _____

Did you go to the hospital after the accident? _____Y/N

How did you get there? ____ ambulance _____ drove yourself ____driven by someone else

When did you go to the hospital? ____ immediately after _____ the next day ____ within a week ____ within a month

If you waited longer than a month what was your reason for waiting?_____

Name of the hospital _____Doctor's Name _____

What type of treatment did you receive? ____ bandages ____ cast ____ neck brace ____ splints ____ collar ____shot

____ medication ____ X-rays ____ antibiotics ____ ice pack ____ hot pack ____ surgery ____crutches

Please give the name and the reason for the medication or shots: _____

Have you seen any other doctors since the accident? ____ Y/N , If so who? _____

Did any part of your body hit any of the following (write in what part of your body hit the car)?

Dashboard _____ Left door _____

Windshield _____ Seat headrest _____

Steering wheel _____ Unknown object _____

Right door _____ Airbag _____

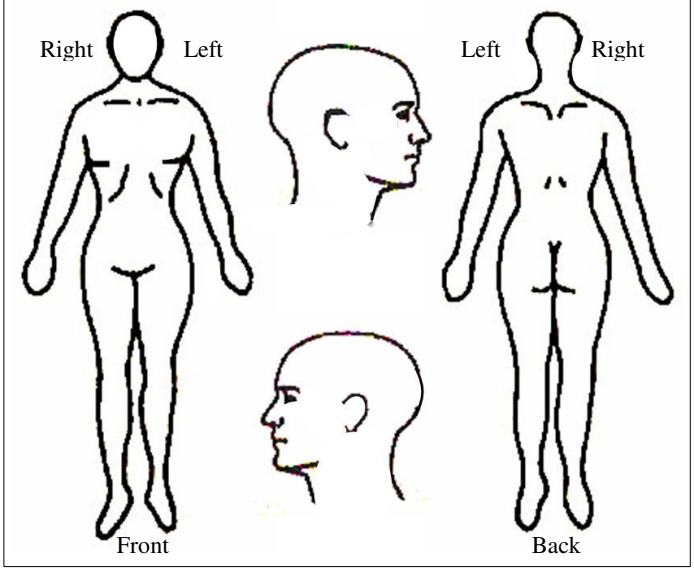
Since the accident, have your symptoms: ____improved ____ worsened ____ stayed the same.

CHECK-OFF ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

1. **Rate your condition from 1 to 10 with 10 being terrible.**
2. **Did the…accident "Cause" or "Aggravate" your condition?**

			Rating
❑ Headaches		Caused / Aggravated	_____
❑ Neck pain		Caused / Aggravated	_____
❑ Upper/Mid back pain		Caused / Aggravated	_____
❑ Lower back pain		Caused / Aggravated	_____
❑ Chest pain		Caused / Aggravated	_____
❑ Shoulder issues	**R L**	Caused / Aggravated	_____
❑ Arm issues	**R L**	Caused / Aggravated	_____
❑ Hand issues	**R L**	Caused / Aggravated	_____
❑ Leg issues	**R L**	Caused / Aggravated	_____
❑ Foot issues	**R L**	Caused / Aggravated	_____
❑ Head heaviness		Caused / Aggravated	_____
❑ Neck stiffness		Caused / Aggravated	_____
❑ Back stiffness		Caused / Aggravated	_____
❑ Pins/needles in arms		Caused / Aggravated	_____
❑ Pins/needles in hands		Caused / Aggravated	_____
❑ Pins/needles in legs		Caused / Aggravated	_____
❑ Pins/needles in feet		Caused / Aggravated	_____
❑ Upset stomach		Caused / Aggravated	_____
❑ Diarrhea		Caused / Aggravated	_____
❑ Constipation		Caused / Aggravated	_____
❑ Fainting		Caused / Aggravated	_____
❑ Blurred vision		Caused / Aggravated	_____
❑ Buzzing/ringing in ears		Caused / Aggravated	_____
❑ Loss of balance		Caused / Aggravated	_____

Please mark your areas of pain on the figures below.



❑ Loss of taste	Caused / Aggravated	_____
❑ Loss of smell	Caused / Aggravated	_____
❑ Anxiety	Caused / Aggravated	_____
❑ Sleeping problems	Caused / Aggravated	_____
❑ Tension	Caused / Aggravated	_____
❑ Other _____	Caused / Aggravated	_____

How would you describe your primary symptoms (check all that apply) ?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

Does pain radiate or travel? ☐Yes ☐No Describe _____

How often is the pain present?

☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or Less)

What makes your problem worse (aggravates)?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying Down
☐ Inactivity ☐ Other _____

Areas of your everyday activities that are (or have been) affected (please check)

- ❑ Sleeping
- ❑ Eating
- ❑ Bathing
- ❑ Getting dressed
- ❑ Going to the bathroom
- ❑ Typing on the keyboard
- ❑ Standing from sitting
- ❑ Standing
- ❑ Walking
- ❑ Sitting
- ❑ Exercise
- ❑ Running
- ❑ Lifting
  - ○ - heavy
  - ○ - medium
  - ○ - light
- ❑ Driving a car
- ❑ Riding a car
- ❑ Vision
- ❑ Feeling
- ❑ Tasting
- ❑ Smelling
- ❑ Emotional stability
- ❑ Housework

PATIENT NAME: _____ Date of Birth: _____
TODAY'S DATE _____

LIFESTYLE

Were you pregnant at the time? Y / N Recovering from surgery? Y / N

Describe your lifestyle before the accident: Active / Moderately active / Inactive

Describe your lifestyle since the accident: Active / Moderately active / Inactive

Describe any other physical changes you have noticed: _____

Name the activities you used to do before the accident: (please check)

- ❑ Job
- ❑ Second job
- ❑ Crafting
- ❑ Housework
- ❑ Marital relations
- ❑ Volunteer work
- ❑ Exercise
- ❑ Dance
- ❑ Sports
- ❑ Carrying/playing with children
- ❑ Hunting
- ❑ Fishing
- ❑ Yard work

How have your injuries affected your ability to do these activities? Explain _____

_____

_____

PATIENT NAME: _____ Date of Birth: _____

TODAY'S DATE _____

Neck Disability Index (Vernon - Minor)

This questionnaire has been designed to give the doctor Information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 'ONE', box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment.

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 everyday in most aspects of self-care.
- ❑ I do not get dressed; I 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 gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (e.g. 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 very light weights
- ❑ I cannot lift or carry anything at all.

SECTION 4- READING

- ❑ I can read as much as I want with no pain in my neck.
- ❑ I can read as much as I, want with slight pain in my neck.
- ❑ I can read as much as I, want with moderate pain in my neck.
- ❑ I can't read as much as I want because of moderate pain in my neck
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

SECTION 5- HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches, which come infrequently.
- ❑ I have moderate headaches, which come infrequently.
- ❑ I have moderate headaches, which come frequently.
- ❑ I have severe headaches, which come frequently.
- ❑ I have headaches almost all the time.

SECTION 6- CONCENTRATION

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I wont to.
- ❑ I cannot concentrate at all.

SECTION 7-WORK

- ❑ I can do as much work as I want to.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 8- DRIVING

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can't drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

SECTION 9-SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❑ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ❑ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10-RECREATION

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities with some neck pain at all.
- ❑ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck
- ❑ I can't do any recreation activities at all

Pain Severity Scale: Rate the severity of your pain by circling a number on the following scale

No Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating Pain

PATIENT NAME: _____ Date of Birth: _____

TODAY'S DATE _____

Low Back Pain and Disability Questionnaire (Revised Oswestry)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 'ONE' box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box, which most closely describes your problem.

SECTION 1- PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

SECTION 2- PERSONAL CARE

- ❑ I would not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

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.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. 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 only lift very light weights at the most.

SECTION 4-WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain on walking but it does not increase with distance.
- ❑ I cannot walk more than one kilometer (km.) without increasing pain.
- ❑ I cannot walk more than ½ km. without increasing pain.
- ❑ I cannot walk more than ¼ km. without increasing pain.
- ❑ I cannot walk at all without increasing pain.

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 more than one hour.
- ❑ Pain prevents me from sitting more than ½ hour.
- ❑ Pain prevents me from sitting more than 10 minuets.
- ❑ I avoid sitting because it increases pain straight away.

SECTION 6- STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

SECTION 7- SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain, my normal nights sleep is reduced by less than ¼.
- ❑ Because of pain, my normal nights sleep is reduced by less than ½.
- ❑ Because of pain, my normal night's sleep is reduced by less than ¾.
- ❑ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

- ❑ My social life is normal and gives me no 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 (e.g. dancing, etc.).
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9- TRAVELLING

- ❑ I get no pain whilst traveling.
- ❑ I get some pain whilst traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done tying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening

Pain Severity Scale: Rate the severity of your pain by circling a number on the following scale

No Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating Pain

PATIENT NAME: _____ Date of Birth: _____

TODAY'S DATE _____

INSURANCE

Your Car Insurance Information

Carriers Name: _____ Phone # _____

Address: _____

Policy #: _____ Claim # _____

Adjustor's Name and Number: _____

Your Health Insurance

Name of Insurance Company _____ Insurance Company Phone # _____

Address: _____ City_____ State_____ Zip Code_____

Policy #: _____ Group # _____ Name of Insured_____

Responsible (At Fault) Parties Insurance

Insurance Carrier's Name:_____ Phone # _____

Address: _____

Policy #: _____ Claim # _____

Adjustor's Name and Number: _____

Attorney Information

Attorney Name _____ Address_____

City _____ State _____ Phone _____

Patient Signature _____ Date _____

Guarantor (if minor) _____

Turn in any photos of the accident damage to you or your car for scanning into your file.

PATIENT NAME: _____ Date of Birth: _____

TODAY'S DATE _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I or my minor child ever has a change in health.

I certify that I, and/or my dependent(s) have insurance with the aforementioned Insurance Companies and assign directly to Chiropractic Works Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Chiropractic Works Health Center may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my currant treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative below:

Signed _____ Dated: _____

PRINT YOUR NAME: _____ Date of Birth: _____

Authorization to Release Med Pay Information

Patient Name: _____
Claim #: _____
Date of Loss: _____

To All Insurance Carriers and Agents:

I am currently being treated at Chiropractic Works Health Center for injuries sustained as a result of an injury accident. Please be advised of the following:

I. I do hereby authorize you to disclose any and all information regarding Med Pay, to include amounts, calendar year, number of visits and any other pertinent information, as it pertains to my personal injury case.

II. I authorize a Photostatic copy of this authorization be accepted with the same authority as the original.

III. This authorization expires upon resolution of this claim.

_____ _____
Patient Signature (or Guardian if Minor) Date

_____ _____
Social Security Number Date of Birth

Assignment of Benefits

TO: Attorney / Insurance Carrier

_____

_____

_____

_____

Dr. Kenneth R. Weil, P.C.
1715 Howell Mill Rd NW C-12
Atlanta, Georgia 30318

Patient Name: _____ Date of Birth: _____
Policy/Claim #: _____

RE: Patient Records, Service Lien, and Assignment of Benefits

I do hereby authorize the above Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center to furnish you, my attorney/insurance carrier, with a full report of their case history, examination, diagnosis, prognosis and service of/to myself in regard to my accident/illness which occurred/began on _____.

I do hereby irrevocably give a lien to Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center on any settlement, claim, judgment or verdict as a result of said accident / illness. I authorize and direct you, my attorney / insurance carrier, to pay directly to Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center such sums from such settlement, claim, judgment or verdict as may be necessary to protect Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center adequately.

I agree never to rescind this document and that my attorney will not honor a rescission, I hereby instruct that, in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if he executed it.

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 but may declare the entire balance due and payable.

I fully understand that I am directly and fully responsible to Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center for all just bills submitted by them for service rendered me, and that this agreement made solely for Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center's protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I eventually recover said fee.

Dated: _____ Patient's Signature: _____

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

Dated: _____ Attorney's Signature: _____
Dated: _____ Insurance Company's Signature: _____

****NOTE: PLEASE DATE, SIGN AND RETURN ONE COPY TO DOCTOR'S OFFICE. ALSO KEEP ONE COPY FOR YOUR RECORDS.**

Chiropractic Works Health Center
Dr. Kenneth R. Weil, P.C.
1715 Howell Mill Road, C-12
Atlanta, Georgia 30318
www.AtlantaChiro.com
(404) 350-8000

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

At Chiropractic Works Health Center, we are committed to protecting your privacy of your personal health information. Federal guidelines have been developed, to protect this information.

I understand that as part of my health care, Chiropractic Works Health Center originates and maintains paper and / or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care
- A means, of communication among the many health professionals who contribute to my care
- A means by which a third-party payer can verity that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out
- Treatment, payment, or health care operations

I understand that Chiropractic Works Health Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations and any and all fees for services provided will be immediately due.

I further understand that Chiropractic Works Health Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Chiropractic Works Health change their notice, they will send a copy of any revised notice to the address provided (US mail).

I wish to have the following restrictions to the use disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient's / Guardian's Signature Date

Patient Name _____ Date of Birth_____