



Dr. James A. Ferraro D.C.
(302) 368-3300



Name: _____ Date: ____/____/____

Address: _____

Street

City

State

Zip Code

Preferred Contact Number: (____) _____ - _____

This number is a: Home __ Cell __ Other __

Email Address: _____

*Concord Chiropractic will not use your e-mail address for anything other than appointment reminders or newsletters

Date of Birth: ____ - ____ - ____ Age: ____

Occupation: _____ Employer's Name: _____

Reason for visit: _____

Who may we thank for referring you to our office? _____

Date of accident: _____ State of accident: _____

Insurance Name: _____ Claim Number: _____

Claims address: _____

Adjuster Name: _____ Adjuster Phone: _____

Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ DOB: _____ Today's date: _____

Date of accident: _____ Time of accident: _____ AM / PM

What are your present complaints / symptoms as a result of the accident? _____

Please check symptoms you have noticed since the accident:

☐ neck pain	☐ loss of balance	☐ upper back pain	☐ cold sweats
☐ stiffness in neck	☐ loss of memory	☐ lower back pain	☐ nervousness / anxiety
☐ headache	☐ face flushed	☐ pins & needles in legs	☐ irritability
☐ dizziness	☐ pins & needles in arms	☐ numbness in legs / feet	☐ fatigue
☐ sensitivity to light	☐ numbness in hand / arm	☐ pain into legs / feet	☐ fainting
☐ head feels "heavy"	☐ pain into arms / hand	☐ cold feet	☐ depression
☐ loss of smell	☐ cold hands	☐ constipation / diarrhea	☐ sleep problems
☐ loss of taste	☐ tension	☐ chest pain	☐ fever
☐ buzzing in ears	☐ ringing in ears	☐ shortness of breath	☐ upset stomach

Did you have any physical complaints before this accident? Yes No

Please describe: _____

Occupation: _____

Have you missed time from work? Yes No If yes, dates missed: From _____ To _____

ACCIDENT DETAILS

Driver of car you were in? _____ Owner of car? _____

Where in car were you seated?

Front – Driver's Side

Front – Passenger Side

Rear – Driver's Side

Rear - Middle

Rear – Passenger Side

In your own words, please describe the accident: _____

Were you given medical attention after the accident?

Yes

No

If yes, how did you get there?

Ambulance

Police

Drove Own Car

Someone Else Drove Me

Other: _____

Name of medical facility: _____

Date of medical examination: _____

Name of doctor seen: _____

Was imaging / testing performed? Yes No

If yes, what kind? X-ray CT MRI Blood Test

Other: _____

Did you receive any form of treatment?

Yes

No

If yes, what kind?

Medication

Brace

Collar

Other: _____

If yes, did the treatment benefit you?

Yes

No

How so? _____

Have you seen anyone else for this condition?

Yes

No

Name of person(s) seen: _____

Do you have an attorney in regards to this claim?

Yes

No

Attorney's name: _____

Law firm: _____

Address: _____

Phone: _____

Where was your car struck?

Head-On Collision

Rear Impact

Non-Collision

Broad-Side Collision on Right

Broad-Side Collision on Left

Other: _____

Please explain damage done to the car you were in: _____

Visibility at time of accident: Poor Fair Good Other: _____

Road conditions at time of accident: Icy Rainy Wet Clear Dark Other: _____

What was your head / body position at the time of impact?

Head Straight Forward

Head Turned Left / Right

Head Looking Back

Body Straight in Sitting Position

Body Turned Left / Right

Other: _____

At the time of the accident, what parts of your head / body hit what parts on the inside of the car?

Did you see the accident coming? Yes No Not Sure

Did you brace for impact? Yes No Not Sure

Were you wearing a seatbelt? Yes No Not Sure

Does the car have headrests? Yes No Not Sure

Was your car braking? Yes No Not Sure

Was your car moving at the time of the accident? Yes No Not Sure

If yes, how fast was your car moving? _____

How fast would you estimate the other vehicle was moving? _____

Please describe how you felt:

- During the accident – _____
- Immediately after the accident – _____
- Later that day – _____
- The next day – _____

ACTIVITIES OF DAILY LIVING ASSESSMENT

DIRECTIONS: Please check the **ONE** item in each section which most closely applies to you.

PAIN INTENSITY

- ☐ I can tolerate the pain I have without painkillers.
- ☐ The pain is bad, but I manage without 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.

PERSONAL CARE

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

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 (i.e. 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 light weights.
- ☐ I cannot lift or carry anything at all.

WALKING

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a cane or a crutch.
- ☐ I am in bed most of the time and must to crawl to the toilet.

SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 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.

STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I can stand as long as I want, but it causes extra pain.
- ☐ Pain prevents me from standing more than 1 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.

SLEEPING

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

SEX LIFE

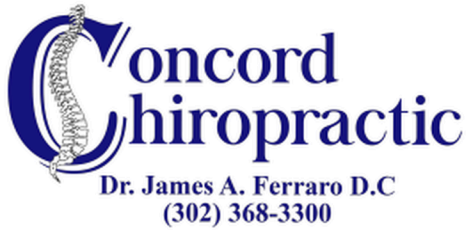
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal, but causes extra pain.
- ☐ My sex life is nearly normal, but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SOCIAL LIFE

- ☐ My social life is normal and without extra pain.
- ☐ My social life is normal, but results in extra pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
- ☐ Pain has restricted my social life and I do not go out as often as I would like.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it causes extra pain.
- ☐ Pain is bad, but I can manage journeys over 2 hours.
- ☐ Pain restricts me to journeys less than 1 hour.
- ☐ Pain restricts me to short necessary trips under ½ hour.
- ☐ Pain restricts me from all travel, except to the doctor or hospital.



Authorization Form

Patient Name: (print) _____

RELEASE OF INFORMATION

I hereby authorize Concord Chiropractic to release medical and financial data to my insurance carriers, other medical facilities, and attorney(s).

Initials: _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered. The undersigned understands that services are rendered and charged to you (the patient) and not your insurance company. Concord Chiropractic does not accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. It is the financial obligation of the undersigned to be responsible for any charges or services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures, or any remaining balance upon completion of settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement.

Initials: _____

CONSENT FOR TREATMENT OF A MINOR CHILD

Consent is hereby given by the undersigned for Chiropractic treatment, X-Rays, Acupuncture, any diagnostic studies as ordered by the doctors, and therapies (therapeutic massage, electrical stimulation, ice/heat therapy, hydrotherapy, therapeutic exercises) performed by the technical staff of Concord Chiropractic. The undersigned states that he/she is the patient's legal guardian.

Initials: _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payments of my medical benefits otherwise payable to me to be made payable and mailed directly to Concord Chiropractic for professional services rendered. No other third party, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledged medical coverage and will send payments directly to this office.

Initials: _____

X _____	_____	____/____/____
Patient or Guardian Signature	Relationship to Patient	Date



INFORMED CONSENT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strain and sprain, fracture, dislocation, disc injuries, temporary exacerbation of symptoms, and altered blood flow to the head and brain.

My doctor has responded to all my requests for information about the proposed treatment. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

Print Patient's Name

Signature of Patient

Date

Print Parent/Guardian Name

Signature of Parent/Guardian

Date

Print Witness Name

Signature of Witness

Date



Release of Medical Records

Patient Name (please print): _____

Date of Birth: ____/____/____

I hereby authorize _____ to release all medical records, or those concerning the dates of treatment on _____, to:

**Concord Chiropractic
20 A Trolley Square
Wilmington, DE 19806**

These records are requested for the purpose of Medical Care. Documents requested should include:

- Discharge Summary
- History and Physical
- Operative Record
- Physician Progress Notes
- Diagnostic Tests and X-ray reports
- Other _____

I understand that this request for release of information stands effective for 120 days. This request may be revoked at any time but is not retroactive for requests that have been complied within good faith. This authorization may be revoked by written request to an authorized representative of Concord Chiropractic.

X _____ / ____/____
Patient's Signature Date

X _____ / ____/____
Signature of Legal Guardian Relationship to Patient Date

Disclosure of specific information for release is limited to the above mentioned recipient only. Federal regulation, 42 CFR Part 2, prohibits the redisclosure of the enclosed information unless the consent expressly permits further disclosure or the redisclosure is otherwise permitted under regulations.