

**Voth Family
Chiropractic, L.L.C.**

**1957 Thompson Rd.
Coos Bay, OR 97420**

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ 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.

The above-named doctor 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 current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

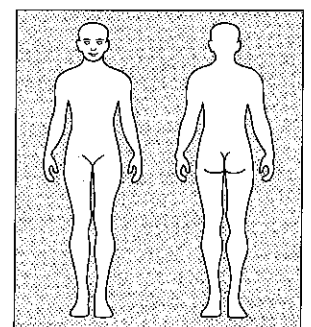
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | |
|---------------------|--|---------------------|--|----------------------|--|------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking _____ Packs/Day
 Alcohol _____ Drinks/Week
 Coffee/Caffeine Drinks _____ Cups/Day
 High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

PHARMACIES

ALLERGIES

VITAMINS/FIBRES/MINERALS

Pharmacy Name _____ Pharmacy Phone (____) _____		
--	--	--

PAIN DIAGRAM

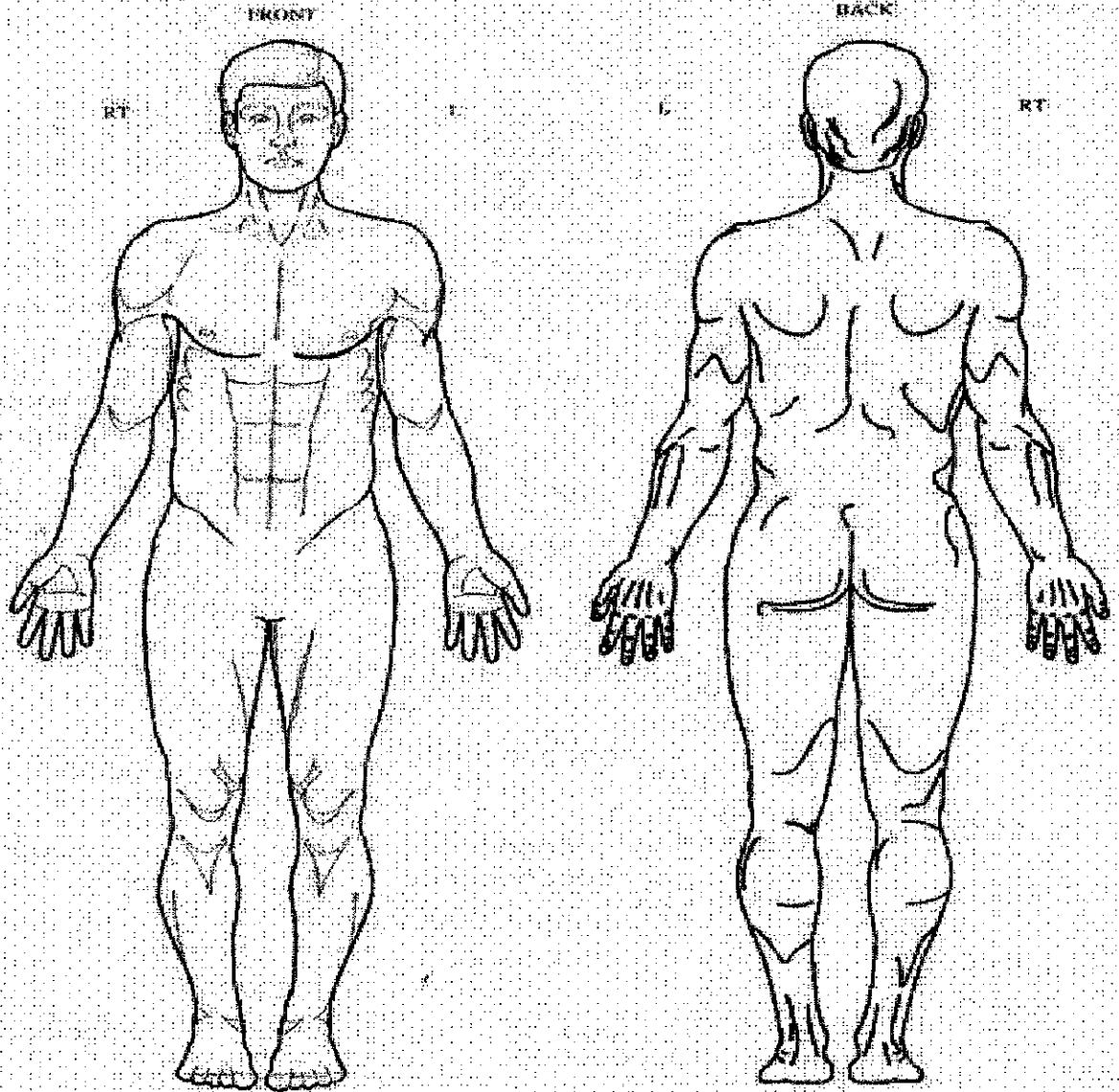
PATIENT NAME: _____

TODAY'S DATE: _____

PLEASE COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)

PATIENT'S SIGNATURE: _____



Voth Family Chiropractic LLC

Benjamin L. Voth, D.C.

1957 Thompson Rd. Suite B Coos Bay, OR 97420

Telephone (541) 266-8000

SIGNATURE ON FILE

I understand that I am responsible for my bill. If it is necessary to refer my account for collection I agree to pay Voth Family Chiropractic L.L.C. reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including appeal, is tried, heard, or decided.

I authorize use of this form on ALL my insurance submissions.

I authorize release of information to all my insurance companies.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Signature of patient (or parent or legal guardian)

Name of patient (please print)

Date

Voth Family Chiropractic LLC
Benjamin L. Voth, D.C.
1957 Thompson Rd. Coos Bay, OR 97420
Telephone (541) 266-8000

Consent Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or the patient named below for whom I am legally responsible).

I am informed and I understand that, as in the practice of medicine, there are some risks to treatment, including, but not limited to, soreness and a temporary worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I understand the results and are not guaranteed. I wish to rely on the doctor to exercise good judgement and prescribe a course of treatment that, based on the facts known, will be in my best interests.

I have read (or have read to me) this consent form. By signing below I agree to the above-named conditions. I intend this consent form to cover the entire treatment for my present condition, and for any future conditions for which I seek treatment at Voth Family Chiropractic LLC.

Print patient's name

Signature of patient or guardian

Date

Voth Family Chiropractic LLC

Benjamin L. Voth, D.C.

1957 Thompson Rd. Suite B Coos Bay, OR 97420

Telephone (541) 266-8000

FINANCIAL AGREEMENT

I _____ understand that I am responsible for payment in full for services provided to me at Voth Family Chiropractic L.L.C.

Please be aware that each modality (therapy) has a reasonable fee. If you do not wish to pay for a particular therapy please let the doctor or a staff member know BEFORE the therapy is performed.

If it is necessary to refer my account for collection I agree to pay Voth Family Chiropractic L.L.C. reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including appeal, is tried, heard, or decided.

I have read (or have had read to me) the above statement and terms, and understand fully the content.

I agree to the terms as stated above.

Signature of Patient
(or parent or legal guardian)

Print patient name

Date

VOTH FAMILY CHIROPRACTIC

Benjamin L. Voth, D.C.

1957 Thompson Rd. Ste. B Coos Bay, OR 97420

REVISED OSWESTRY LOW BACK PAIN AND DISABILITY

Patient Name: _____

Date: ____/____/____

Please read instructions carefully:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in **ONE** circle 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 very severe.
- The pain is severe and doesn't vary much.

SECTION 2 - PERSONAL CARE

- I can look after myself 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 can manage most of my personal care.
- I need help every day 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 weight without extra pain.
- I can lift heavy weight but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 - WALKING

- I have no pain walking.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I can walk with crutches.
- 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 a half hour.
- Pain prevents me from sitting more than 10 minutes.
- 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 1/2 hour without increasing pain.
- I can't 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 doesn't prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by < 1/4.
- Because of pain my normal night's sleep is reduced by < 1/2.
- Because of pain my normal night's sleep is reduced by < 3/4.
- Pain prevents me from sleeping at all.

SECTION 8 - TRAVELING

- I get no pain while traveling.
- I get some pain while 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 are done lying down.

SECTION 9 - SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain limits 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 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.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

VOTH FAMILY CHIROPRACTIC

Benjamin L. Voth, D.C.

1957 Thompson Rd. Ste. B Coos Bay, OR 97420

The Oswestry Neck Disability Index (Confidential)

Patient Name:

Date:

Please check only **ONE** statement in each section that describes how you're feeling **TODAY**

<p>Section 1 - Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> Pain is very mild at the moment.</p> <p><input type="checkbox"/> Pain is moderate at the moment.</p> <p><input type="checkbox"/> Pain is fairly severe at the moment.</p> <p><input type="checkbox"/> Pain is very severe at the moment.</p> <p><input type="checkbox"/> Pain is the worst imaginable at the moment.</p>	<p>Section 6 - Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p>Section 2 - Personal Care (Washing, Dressing, etc)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self care.</p> <p><input type="checkbox"/> I do not get dressed. I wash with difficulty and stay in bed.</p>	<p>Section 7 - Work</p> <p><input type="checkbox"/> I can work as much as I want to.</p> <p><input type="checkbox"/> I can only do my usual work but no more.</p> <p><input type="checkbox"/> I can do most of my usual work but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p>
<p>Section 3 - Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</p> <p><input type="checkbox"/> I can lift heavy weight items if conveniently positioned.</p> <p><input type="checkbox"/> I can lift light/medium weights if conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p>Section 8 - Driving</p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as desired with light neck pain.</p> <p><input type="checkbox"/> I can drive my car as desired with moderate neck pain.</p> <p><input type="checkbox"/> I cannot drive my car much because of moderate neck pain.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car at all.</p>
<p>Section 4 - Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can just read as much as I want with moderate neck pain.</p> <p><input type="checkbox"/> I cannot read as much because of moderate neck pain.</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p>	<p>Section 9 - Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is mildly disturbed (less than 1 hour sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hours sleepless).</p>
<p>Section 5 - Headaches</p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p>Section 10 - Recreation</p> <p><input type="checkbox"/> I can engage in all my recreational activities with no neck pain.</p> <p><input type="checkbox"/> I can do all recreation activities with some neck pain.</p> <p><input type="checkbox"/> I can do most, not all recreational activities with some neck pain.</p> <p><input type="checkbox"/> I can do some recreational activities with neck pain.</p> <p><input type="checkbox"/> I can hardly do recreational activities because of neck pain.</p> <p><input type="checkbox"/> I cannot do recreational activities at all.</p>
<p>Section 11 - Rate your overall pain: 0 1 2 3 4 5 6 7 8 9 10</p> <p style="text-align: center;">No pain mild discomfort distressing horrible excruciating</p>	

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from:

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No

If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since your injury, please check:

- Arm/shoulder pain
- Back pain
- Back stiffness
- Chest pain
- Dizziness
- Ear buzzing
- Ear ringing
- Fatigue

- Feet/toe numbness
- Hand/finger numbness
- Headaches
- Irritability
- Jaw problems
- Leg pain
- Memory loss
- Nausea

- Neck pain
- Neck stiff
- Shortness of breath
- Sleep difficulty
- Stomach upset
- Tension
- Vision blurred

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

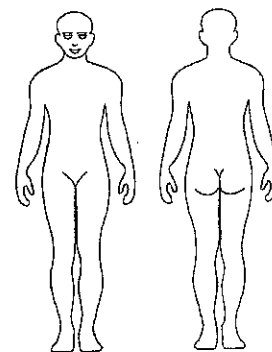
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Movements that are painful to perform: Sitting Standing Walking
 Bending Lying Down



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 have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Voth Family Chiropractic LLC

Benjamin L. Voth, D.C.

1957 Thompson Rd. Coos Bay, OR 97420

Telephone (541) 266-8000

FINANCIAL AGREEMENT FOR AUTO ACCIDENT PATIENTS

Voth Family Chiropractic LLC will gladly bill your auto insurance company for chiropractic services relating to your recent automobile accident. The insurance of the owner of the automobile you were driving or riding in at the time of the accident is known as "your insurance company".

You must provide us with accurate information regarding the accident and the auto insurance.

If your insurance company denies payment for any reason you are responsible for payment in full of Voth Family Chiropractic LLC charges. We may bill your group health insurance at that time if you would like us to. We will be willing to set up a payment plan if necessary. Voth Family Chiropractic LLC might run a credit check on you.

If your insurance company denies payment and you wish to appeal their decision we MUST have a lien and a release of information form filed with your attorney. If these conditions are met we will be happy to set up a workable payment plan until you and your attorney have reached a settlement with your insurance company, provided you do not have any liens or judgements that precede us.

If it is necessary to refer this account for collection you agree to pay Voth Family Chiropractic LLC reasonable attorney fees and collection costs including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney fees or collection charges shall be fixed by the court or courts in which the suit or action, including any appeal, is tried, heard, or decided.

I have read (or have had read to me) the above statements and understand fully the content. I agree to the terms as stated above.

Print patient name

Signature of patient (or parent or legal guardian)

Date

Witness

Date