KATZ CHIROPRACTIC AND REHABILITATION CLINIC
FRONT RANGE DIGITAL MOTION X-RAY
2727 Pine Street, Unit 1, Boulder, Colorado 80302
Office: 303-938-9070 ~ Fax: 303-938-9170

CAD INJURY HISTORY FORM

GENERAL INFORMATION:
Patient Name: _____ Today's date: _____ Date of Injury: _____
Were you employed at time of the crash? ___ Y ___ N Are you currently employed? ___ Y ___ N
If no, is your unemployment status due to the crash? ___ Y ___ N
Type of work: ___ Office/Clerical ___ Light Labor ___ Moderate Labor ___ Heavy Labor

INJURY HISTORY:
Was the crash on the job? ___ Y ___ N
You were: ___ Driver ___ Front seat passenger ___ Rear seat passenger ___ Motorcycle operator ___
Motorcycle passenger ___ Other: _____
Vehicle driven by: _____
Your vehicle year/make/model: _____
Your estimated speed at the moment of the crash: ___ Stopped ___ Slowing ___ Accelerating
Other vehicle year/make/model: _____
Time of day: ___ Daylight ___ Dawn ___ Dusk ___ Dark
Road conditions: ___ Dry ___ Damp ___ Wet ___ Snow ___ Ice ___ Other: _____
Head restraints: ___ None ___ Integral type ___ Adjustable ___ Up ___ Down ___ Don't Know
If adjustable, was the position altered by the crash? ___ Y ___ N
Was the seat back adjustment altered by the crash? ___ Y ___ N
Was the seat broken? ___ Y ___ N Seat belt: ___ Wearing ___ Not wearing ___ Don't Know
Did the air bag deploy? ___ Y ___ N If yes, were you struck? ___ Y ___ N
Body position: ___ Good ___ Forward lean ___ Other: _____
Head position: ___ Forward ___ Left ___ Right ___ Up ___
Down Hand position: ___ One on the wheel ___ Two on the wheel ___ N/A
Brakes applied? ____ Y ____ N
Were you aware of impending crash? ___ Y ___ N

DURING THE CRASH:
Did you strike any parts of the vehicle? ___ Y ___ N
If yes, describe: _____
Did the vehicle strike any objects after impact? ___ Y ___ N
If yes, describe: _____
Wearing hat or glasses? ____ Y ____ N If yes, were they still on after the crash? ___ Y ___ N
Did you lose consciousness? ___ Y ___ N If yes, for how long? _____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle(s): ___ None ___ Minimal ___ Moderate ___ Major
Were the police on-scene? ___ Y ___ N
If yes, was a report made? ___ Y ___ N

AFTER THE CRASH:
Symptoms: ___ Headache ___ Dizziness ___ Nausea ___ Confusion/disorientation ___ Neck pain ___
Parasthesia(s) If yes, where?_____ ___
Extremity pain? If yes, where? _____ Back pain? ___ Y ___ N
When did symptoms first appear? _____

AFTER THE CRASH (CON'T)
Immediately (describe which symptom & how many hours afterward) _____
Where did you go after the crash? ___ Home ___ Work ___ Hospital
Mode of transportation: _____

CRASH DETAILS

_____
_____
_____
_____
_____
_____

CRASH DIAGRAM

EMERGENCY DEPARTMENT:
Radiographs: ___ Y ___ N
Body parts imaged: _____
Results _____ Lab work ___ Y ___ N
Cervical collar ___ Y ___ N Ice ___ Y ___ N
Medications: _____
Other : _____
Follow up instructions: ___ Y ___ N If yes, explain _____
Have you had any prior treatment for the injuries sustained in this crash (ie. emergency room, family physician, physio) __ Y __ N

PAST MEDICAL HISTORY:

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal Injuries (date, TX, awards, residuals): _____

Sports or other injuries to head, neck, or back: _____

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MEDICAL PAYMENT BILLING OR SELF PAY OPTIONS

Welcome to Katz Chiropractic and Rehabilitation Clinic/Front Range Digital Motion X-Ray. We will provide you with the best medical care of your injuries. The following information is needed to bill for your treatment. Under current Colorado Law you have choices:

1. You can pay for each visit at the time of service, or

2. We can bill insurance for you; which will be usual, customary and reasonable insurance rates. In order to bill for you, we need the following (no exceptions, unless waiver at bottom is signed):

    a. At Fault Driver's insurance info
    b. Your auto insurance info
    c. Your health care insurance info and copy of insurance card

    The reason for all this information is that we have to file the claim in a timely manner to the insurance companies. We may also have to obtain authorization for your treatment. Since your auto insurance or the at-fault driver's auto insurance may be limited, we need your health care insurance card. By Colorado law, your health care insurance (if applicable) must pay the remainder of bills once auto insurance has fulfilled their payment limitations.

I agree to provide the above information in full (a-c). In addition, I fully understand that the self-pay is a discounted fee and the insurance rates are based on your chiropractic adjustments and physical therapy.

_____ _____

Patient Signature Date

WAIVER OF PRESENTATION OF ALL REQUESTED INSURANCE INFORMATION
I am not providing the full requested information. I have been informed that if Katz Chiropractic cannot bill and authorize ALL the appropriate insurances, I am fully responsible for the unpaid medical bills.

_____ _____

Patient Signature Date