Oakville Health and Rehab Center
Vehicle Accident Questionnaire

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please PRINT and be as accurate and complete as possible.

Personal Information

Name:________________________________ Date:______________
Address:______________________________ Phone:______________
City:_______________________ State:__________ Zip:__________
Date of Birth:________________ Age:___________________________
Marital Status:___S___M___D___W # of Children:_______ Occupation:__________
Employer:______________ Address:________________ Phone:__________

Accident Information

Date of Accident:____________________ Time of accident:______________
Were you:___Driver ___Front Passenger ___Back Passenger Wearing seat belt? ___Y ___N
Details of how accident occurred:_______________________________________
____
____
____

Were police notified?___Y___N Your vehicle was struck on the __Front __Back __Left __Right
Were you unconscious?____Y____N If so, for how long?__________________
Where were you taken after the accident?_______________________________
Exact area(s) of pain immediately after accident:__________________________
____
What diagnosis was given?____
What treatment was given?____
Have you consulted another doctor? If so, give name, address, and phone number.__________
____
Have you missed work since the accident? _____Y_____N
Have you returned to work since the accident? _____Y_____N If so, what date?__________

Medical Information

What is your main area of concern currently?______________________________
When did this begin?____
What makes it feel better?____________________ Worse?___________________
What does it feel like (ache, burn, tingle, etc)?_____________________________
Does the pain travel to any other areas?___Y___N If so, where?________________
Is the pain constant or intermittent?____________________________________
When or what causes the pain to occur?__________________________________

Have you had any diseases or illnesses as a child?__________________________
Do you currently suffer from any diseases or illnesses?_______________________
Have you ever been hospitalized? If so, please explain.________________________
____

Please list any medications you are currently taking along with the dosage, what condition they are for, and how long you have been taking them:______________________________

____

____

Do you have any allergies to medicine?______________________________

What medical conditions are you now suffering from?______________________________

____

What medical conditions are you currently being treated for?______________________________

____

When was your last physical exam/check-up?______________________________

Please list any supplements, vitamins, minerals, herbs, etc. that you are currently taking:_______

____

Please list any injuries you have had that required medical attention (such as broken bones):____

____

Please list any surgeries/operations you have had and when you had them:______________

____

Please list and explain any diseases or conditions you have had involving the following- heart, stomach, kidneys, blood, pancreas, spleen, glands, spinal cord, joints, lungs, intestines, bladder, thyroid, liver, hormones, brain, muscles or cancer:______________________________

____

Do any relatives in your immediate family suffer from hypertension, diabetes, cancer, stroke, or heart attack? If so, who?______________________________

Please list any other diseases that run in your family:______________________________

Do you consume alcohol? _____ Yes _____ No ______ Occasionally

Do you smoke? ___Y ___N How many packs per day?________ For how long?____________

Do you chew tobacco? ____Y____N If so, how often?______________________________

Have you lost or gained weight recently?___Y___N How much in how long?____________

Do you know what has caused this weight change?______________________________

Have you had fevers/chills lately?___Y___N Have you had vision problems lately?___Y___N

Have you had neck pain or neck problems lately?___Y___N

Please check any of the following conditions that you have recently experienced:

__Chest pain

__Tightness

__Shortness of breath

__Fatigue

__Feeling your heart beat in your chest

__Nausea

__Vomitting

__Abdominal pain

__Diahrrea

__Other problems going to the bathroom

Have you had any difficulty urinating or any bladder infections in the past?______________

Have you ever had any sexually transmitted diseases?__Y__N If so, what disease(s) and when?______________________________

Have you recently experienced difficulty moving any body parts?______________________________

Have you ever been treated by a psychiatrist/psychologist?__Y___N If so, when and what for?

____

Patient Health Information Consent Form (HIPPA)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations, we must require that you read and sign this consent form stating that you understand and agree to how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage that you read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understand and agrees to allow Oakville Health and Rehab Center to used their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and the coordination of care. As an example, the patient allows this chiropractic office to submit requested PHI to the patient's health insurance company/companies provided to us by the patient for payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company/companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her health records at any time and require corrections if needed. The patient may request to know what disclosures have been made and submit in writing and further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke any consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff members have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.
6. Patients have the right to file a formal complain with our privacy official about any possible violation of these policies and procedures.
7. If the patient refuses to sign this consent form for the purpose of treatment, payment, and healthcare operations, the chiropractic physician has the right to refuse to give the patient care.

I have read and understand how my Patient Health Information (PHI) will be used, and I agree to these policies and procedures state above.

____

Patient Signature   Date

Oakville Health and Rehab Center
Dr. Ronald V. Arconati, D.C.
Dr. Michael W. Hines, D.C.

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain presently prevents you from doing what you would normally do. Regarding each category, please indicate the overall impact your present pain has on your life, not just when the pain is at its worst.

*Please **circle** the number which best describes how your typical level of pain affects these six categories of activities:*

1. *Family/home responsibilities such as yard work, chores around the house, or driving the kids to school.*

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

2. *Recreation including hobbies, sports, or other leisure activities*

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

3. *Social activities including parties, theater, concerts, dining out, and attending other social functions.*

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

4. *Employment including volunteer work and homemaking tasks.*

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

5. *Self-care such as taking a shower, driving, or getting dressed.*

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

6. *Life-support activities such as eating and sleeping.*

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

Patient Name: ______________________________ *Date:* ______________

Total Score: ____________