VAN WORMER HEALTHCARE CLINIC ● 2850 MANHATTAN BLVD. STE A HARVEY, LA 70058 ● (504) 362-3000 ● WWW.DRVANWORMER.COM

PATIENT- BLACK INK STAFF-RED INK DOCTOR-BLUE INK

INCIDENT INFORMATION FORM

Date of this Incident: _____ Time of Incident: _____am/pm

Did you report this incident? Yes / No Do you have a Police Report? Yes / No

At the time of collision were you: Stopped / Slowing / Accelerating / Moving with traffic

Road Conditions: Dry / Wet / Other _____

Collision type:Head-on / Rear-end / Front-end T-bone or Side- swipe: Driver's Side/ Passenger's side

Was there more than one impact? Yes/No

Did you see the impact coming? Yes / No Did you brace for the impact? Yes/ No

Were you the Driver/ Front Passenger/ Backseat (Driver side/ Middle/ Passenger side)

Seat Belt: Wearing / Not Wearing Headrest: Above head/ Middle of head/ Below head

Head/Body Position just before impact:

( ) Head straight forward ( ) Body straight in sitting position
( ) Head looking back ( ) Body rotated left/right
( ) Head turned left/right ( ) Body leaning on console or door

Did your head or body strike any parts of the vehicle? Yes / No Describe: _____

Did the air bag deploy? Yes/ No If yes, did it strike you? Where _____

Who was in the vehicle with you? _____

Your vehicle (model& year):_____

Other vehicle (model & year):_____

Is this your first motor vehicle collision EVER? Yes/ No Date of last incident:_____

Did your vehicle strike any objects: Yes/ No If yes, what? _____

Did you experience: Blurred vision? Yes / No Ringing in the ears? Yes / No
Dizziness? Yes / No Loss of consciousness? Yes/ No

Did you go to the hospital after the incident? Yes / No If yes, what hospital _____
By ambulance? Yes / No
Have you seen any other doctors? Yes / No Who? _____
Were X-Rays taken? Yes / No If yes, what X-Rays?_____
Were medications given? Yes / No If yes, what medications? _____

Since the incident, have you had any:
Bruising: Yes/ No If yes, where? _____ Cuts: Yes/ No If yes, where? _____
Fractures: Yes/ No If yes, where? _____ Difficulty (sitting / standing / lying) since the incident? Yes/ No

WORK STATUS

Have you missed any work since the incident? Yes / No If yes, how many days? _____
Have you returned to work? Yes/ No With restrictions? Yes/No If yes, describe _____

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MEDICAL HISTORY

Primary care physician_____ Phone # _____

Have you been treated for any health condition by a physician in the last year? Yes/ No If yes, explain_____

_____

Have you EVER been treated for back or neck issues? _____

Please date & describe any Surgeries/Fractures/Falls/Other Incidents: _____

_____

If you are female, are you possibly pregnant? Yes/No Date of last menstrual cycle_____

Do you or a family member have of any of the following:

Diabetes/ Stroke/ Cancer/ Heart Condition/ High Blood Pressure/ Psychological disorders

Other: _____

Relation: _____

Please list any & all medications you are taking (include over the counter):

Name & Medication Instructions:_____

_____

_____

	None	Light	Moderate	Heavy
Exercise				
Smoke				
Drink Alcohol				
Experience stress				

Present Complaint(s)

Name: _____Date:_____

When did the pain start? _____

How did the pain start? _____

Did you see your primary doctor or go to an emergency room? _____

Please check ALL that apply to your current condition:

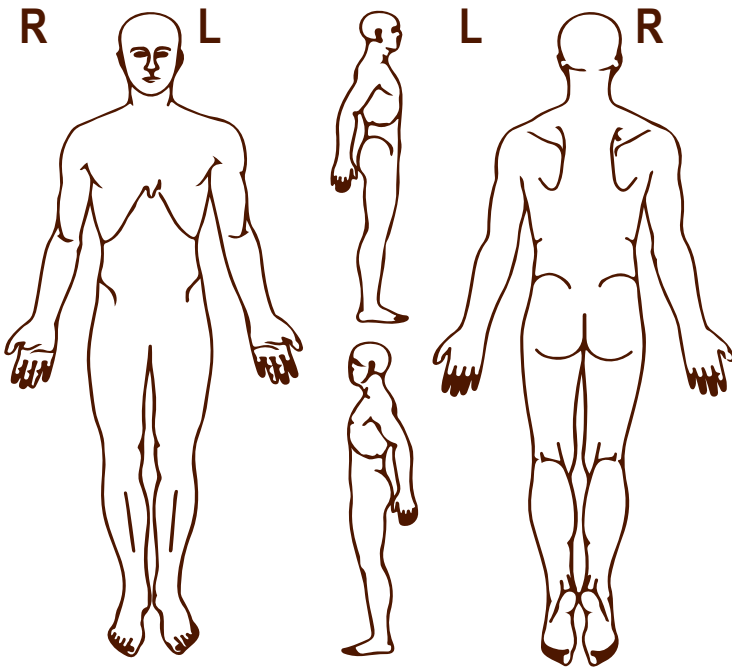
_____Headaches	_____Vision Problems (R L B)	_____Nausea
_____Neck Pain	_____Hearing Problems (R L B)	_____ Difficulty Swallowing
_____Upper Back Pain	_____Dizziness	_____Confusion
_____Mid Back Pain	_____Irritability	_____Facial TMJ (R L B)
_____Lower Back Pain	_____Fatigue	_____Other_____
_____Pelvis/Chest/Abdomen Pain	_____Anxiety/Depression	

_____ Shoulder/Arm/Forearm/Elbow Pain	❑ Right	❑ Left	❑ Both
_____ Wrist/Hand/Finger Pain	❑ Right	❑ Left	❑ Both
_____ Hip/Thigh/Knee/Leg Pain	❑ Right	❑ Left	❑ Both
_____ Ankle/Foot/Toe Pain	❑ Right	❑ Left	❑ Both

Is the pain worse when you cough or sneeze? Yes / No Has it disturbed your sleep? Yes / No

Has it affected any other systems? Yes / No Urinary / Bowel / Cardiac / Respiratory / Vision

Has the pain affected: ❑ Work ❑ Hobbies ❑ Relationships ❑ Household Chores



SHOW US WHERE YOU HURT

Please read carefully:

Using the drawings on the left, mark the areas on your body where you feel pain. Include ALL affected areas. If your pain radiates, draw an arrow from where it starts to where it stops, extending the arrow as far as the pain travels.

Use the appropriate symbols listed below.

Ache >>	Numbness ==	Pins & Needles oo
>>	==	oo
Burning xx	Stabbing //	Throbbing ~~
xx	//	~~

PATIENT INFORMATION

Last Name: _____ First Name: _____ Sex: M / F

Address: _____ City: _____ State: ___ Zip: _____

Home Phone _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: ____ Marital Status: Single Married Divorced Widowed

Social Security #: _____-_____-_____ Driver's License #: _____

Emergency Contact: _____ Relation: _____

Emergency Contact #:_____

HOW DID YOU HEAR ABOUT US? _____

Employed / Unemployed / Student / Homemaker

Employed by: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip:_____

Attorney's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip:_____

Insurance of person at fault: _____ Phone # _____

Insured's Name: _____ Phone # _____

Address:_____ City:_____ State: _____ Zip: _____

Policy # _____ Claim # _____

Your Auto Insurance Co.: _____ Phone # _____

Insurance Company:_____ Policy#:_____ **Claim #:** _____

Health Insurance: _____ Phone #: _____

Policy#: _____ Group # _____

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balance at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from my insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and 25% attorney's fees. I authorize the release of any information pertinent to my case to the insurance company.

Signature_____ Date_____

Louisiana Law requires physicians and other healthcare providers to make certain disclosures to a patient when they refer a patient to another healthcare provider or facility in which the physician has a significant financial interest. If medically necessary, I may refer you, or the named patient for whom you are a legal representative to: Injury Treatment Center New Orleans, 6225 S. Claiborne Ave. Ste. B, New Orleans, LA 70125. I, George Van Wormer DC, have a significant financial interest in the healthcare provider to whom we are referring you. I, the below named patient, or legal representative, hereby acknowledge receipt of a copy of the foregoing Disclosure of Financial Interest.

_____ _____

Print Patient's Name Signature of Patient Date

FUNCTIONAL COMORBIDITY INDEX

Comorbidities: Two or more disease processes occurring at the same time have shown to delay recovery of soft tissue injuries.

The Functional Comorbidity Index (FCI) was developed specifically for use in the general population with physical function, not mortality, as the outcome of interest. The FCI can be used to adjust for the effect of comorbidity on physical function in the same manner that other indices are used to adjust for the effect of comorbidity on mortality.

-Abbreviations-
ARDS: acquired respiratory distress syndrome
BMI: body mass index
COPD: chronic obstructive pulmonary disease
FCI: functional comorbidity index
TIA: transient ischemic attack

Check any that apply:

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Asthma
- ☐ COPD, ARDS, or emphysema
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Neurological disease
- ☐ Stroke or TIA
- ☐ Peripheral vascular disease
- ☐ Diabetes
- ☐ Upper gastrointestinal disease
- ☐ Depression
- ☐ Anxiety or panic disorders
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Degenerative disc disease
- ☐ Obesity and/or BMI >30

Score = 0-18

REFERENCE: Groll DL, To T, Bombardier C, Wright JG. The development of a comorbidity index with physical function as the outcome. J Clin Epidemiol. 2005;58(6):595-602.
PMID: 15878473

VAN WORMER HEALTHCARE CLINIC

Chiropractic & Medical Services

CHIROPRACTIC ORTHOPEDICS MEDICAL

GEORGE VAN WORMER, DC

LICENSE TO PRACTICE:

- Louisiana #541

QUALIFIED EXPERT WITNESS:

- Jefferson Parish
- Orleans Parish
- Plaquemines Parish
- Terrebonne Parish

PROFESSIONAL MEMBERSHIPS:

- Chiropractic Association of Louisiana

JESSE D. SELSER, DC
License #1642

RYAN POLLARD, DC
License #1784

JAMES TODD, MD
License # 017458
Board Certified: Orthopedic Surgeon

GINA L. DEAN, MD
License # 205058
Board Certified: Emergency Medicine

KENNETH WILLIAMS, MD, FAAPMR
License #9967, #545
Board Certified:

- Physical Medicine and Rehabilitation
- Brain Injury Medicine

BERNARD A. LANDRY, MD, FACR
License # 018244
Diplomate: American Board of Radiology

CONSENT FOR TREATMENT OF MINOR

I _____ am the parent/guardian/custodian

of _____, date of birth _____

who is currently a minor.

I hereby authorize Van Wormer Healthcare Clinic to provide chiropractic and medical care to my dependent, including, but not limited to, any examinations, x-rays, and medical and chiropractic treatment.

_____ _____

PARENT/GUARDIAN/CUSTODIAN DATE

_____ _____

PARENT/GUARDIAN/CUSTODIAN DATE

_____ _____

WITNESS DATE