

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 _____

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vision Problems (R L B) | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hearing Problems (R L B) | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Facial TMJ (R L B) |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pelvis/Chest/Abdomen Pain | <input type="checkbox"/> Anxiety/Depression | |

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Shoulder/Arm/Forearm/Elbow Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Wrist/Hand/Finger Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Hip/Thigh/Knee/Leg Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ankle/Foot/Toe Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> 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

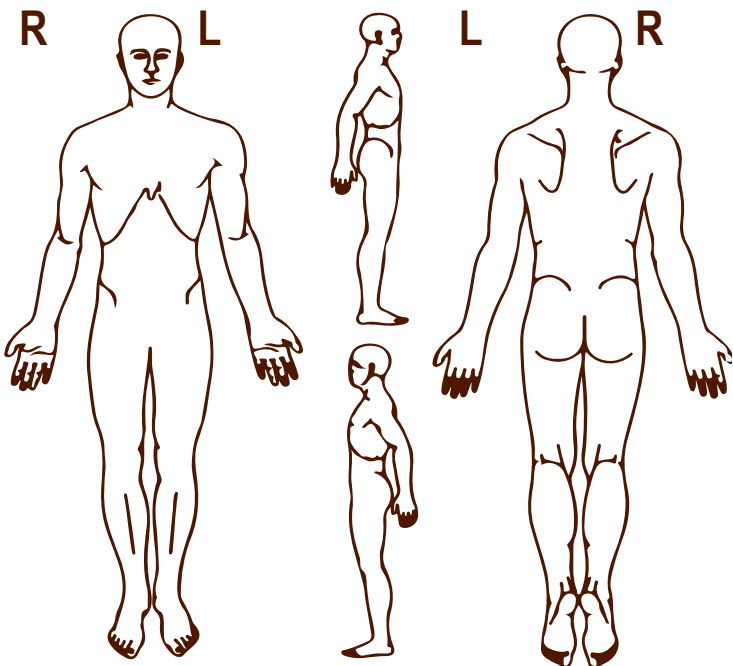
SHOW US WHERE YOU HURT

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 & oo |
| >> | == | Needles 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 or attorney to this office. I understand that I am personally responsible for any remaining balance this office does not collect regardless of settlement from any lawsuit or 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.

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, 3714 Airline Drive, Metairie, LA 70001. 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



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