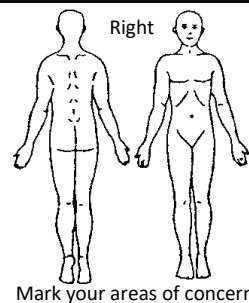




**ACCIDENT QUESTIONNAIRE**

Describe how you felt...(please be as specific as possible):

Immediately after the accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Later the same day: \_\_\_\_\_  
 \_\_\_\_\_  
 During the first night: \_\_\_\_\_  
 \_\_\_\_\_  
 The following day: \_\_\_\_\_  
 \_\_\_\_\_



Mark your areas of concern.

Check all symptoms apparent SINCE the accident, circle severity as appropriate and describe pain (i.e., dull, sharp, stabbing, aching, throbbing, burning, radiating, pressure, etc.):

Head pain feels _____	0	1	2	3	4	5	6	7	8	9	10
Neck pain feels _____	0	1	2	3	4	5	6	7	8	9	10
Mid back pain feels _____	0	1	2	3	4	5	6	7	8	9	10
Low back feels _____	0	1	2	3	4	5	6	7	8	9	10



- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Loss of smell           | <input type="checkbox"/> Loss of taste    | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Numbness in fingers     | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Cold hands          | <input type="checkbox"/> Cold feet               |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Fainting                |
| <input type="checkbox"/> Irritability            | <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ringing/buzzing in ears |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Loss of balance         |
| <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cold sweats             |
| <input type="checkbox"/> Other _____             |   |  |  |

Since the onset, have your symptoms been getting:  Better  Worse  No Change

Do your symptoms interfere with:  Sleep  Work  Daily Routine  Recreation

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Have you missed work?  Yes /  No  Unable to work since accident  
 Full-time off work From \_\_\_\_\_ To \_\_\_\_\_  
 Part-time off work From \_\_\_\_\_ To \_\_\_\_\_

Did you seek medical attention soon after the accident?  Yes /  No  
 If yes, how did you get there?  I drove  Ambulance  Someone else drove me  
 Police  Other: \_\_\_\_\_

Urgent Care / Hospital / Doctor seen: \_\_\_\_\_ Date: \_\_\_\_\_

Examined?  Yes /  No X-rays taken?  Yes /  No If yes, area: \_\_\_\_\_

What treatment did you receive?  Bed rest  Brace  Physiotherapy  Pain medication  Other \_\_\_\_\_

How did treatment help? \_\_\_\_\_ Last treatment date: \_\_\_\_\_

Describe physical complaints you had prior to accident: \_\_\_\_\_



SURGICAL HISTORY	ALLERGIES OR REACTIONS TO MEDICATION
List with year:	

CURRENT MEDICATION/SUPPLEMENTS
Please list all medications or supplements with dose and frequency:

PERSONAL HEALTH INFORMATION			
<b>HEALTH HABITS</b>	Alcohol: _____glasses / day week month Caffeine: _____glasses / day week month Tobacco: _____packs / day week month Stress:   None   Moderate   Daily   Heavy Exercise: None   Moderate   Daily   Heavy	<b>WORK ACTIVITY</b>	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Computer <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Hazards <input type="checkbox"/> Repetitive
		<b>FEMALE HEALTH</b>	Date of last menses: _____ <input type="checkbox"/> Menopause Age of first period: _____ <input type="checkbox"/> PMS Menses: <input type="checkbox"/> Spotting <input type="checkbox"/> Light <input type="checkbox"/> Heavy <input type="checkbox"/> Irregular <input type="checkbox"/> Painful <input type="checkbox"/> Clots <input type="checkbox"/> Absent Are you currently pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N Are you currently breast feeding? <input type="checkbox"/> Y <input type="checkbox"/> N # of pregnancies: _____   # of live births: _____

Any additional information we need to know about your accident and/or your health prior to this accident:

### INFORMED CONSENT

I hereby request and consent to the performance of acupuncture, chiropractic, naturopathy, and/or massage treatments and other procedures within the scope of practice of my provider on me (or on the person named below, for whom I am legally responsible) by the practitioner I see now or other practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for my practitioner, including those working at the clinic or office listed above, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, chiropractic, naturopathy moxibustion, cupping, electrical stimulation, ultrasound, Tui-na (oriental manual therapy), massage, herbal medicine, exercise and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that chiropractic therapy is a generally safe method of treatment, but that it may have some side effects including non-painful cavitations or "popping" and soreness in the area following treatment. The cavitation or "popping" commonly occurs during an adjustment and is caused by the joint fluid converting from a liquid to a gas and is a normal side effect of the treatment. Unusual risks of chiropractic treatments include soft tissue injury, physical therapy burns, rib fracture and very rare disc herniation and stroke. I understand that while this document describes the major risks of chiropractic treatment, other side effects and risks may occur.

I have been informed that naturopathy is a generally safe method of treatment, but that it may have some side effects, including bruising, non-painful cavitations or "popping" and soreness in the area following treatment, dizziness, or fainting. Unusual risks of joint mobilization include soft tissue injury, physical therapy burns, rib fracture and very rare disc herniation and stroke. Bruising is a common side effect of cupping or instrument assisted soft tissue manipulation. Bruising, soreness, or allergic reaction may be side effects of blood draws, IV transfusions, or injections. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that massage therapy is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, and the possible aggravation of symptoms after treatment.

The herbs and nutritional supplements that have been recommended are traditionally considered safe when prescribed by competently trained practitioners. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

### CLINIC POLICIES AND PROCEDURES

**Insurance billing:** We will bill your insurance for you. You are responsible for any amounts applied to your deductible.

**Appointment changes:** your appointment time is reserved specifically for you. In the event of a missed appointment, you may be charged a fee.

**Closure due to inclement weather:** in the case of inclement weather please call the clinic prior to your appointment. Our status will be noted on our voicemail.

### INSURANCE ASSIGNMENT AND RELEASE

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatment, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, the undersigned, hereby instruct and direct my insurance company to pay by check, made out and mailed directly to the above named office, the professional and medical expense benefits allowable and otherwise payable to me under my current policy agreement as payment toward the services rendered. I understand that I am financially responsible for all charges for services provided me (or my dependent). A photocopy of this assignment shall be considered as effective and valid as the original.

Responsible party name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Eric Strand, DAC, PhD ♦ Daniel DesJardins, DC  
Christina Lambert, LAC ♦ Megan Gomez, DC ♦ Jessica Ulmer, LMT ♦ Brooke Braga, LMT