West Portland Chiropractic

Dr. Matthew Todd DC
322 NW 5th Avenue, Suite 305, Portland, OR 97209
p: (207) 370-8516 f: (503) 227-0206
WestPortlandChiropractic@gmail.com

Name _____________________________ Date of Birth ____________ Phone _______________
Address_______________________ City _________________ State _______ Zip ______________
Email: ________________________________ Employer's Name ________________________
Employer's Address ____
Your Ins. Co. _________________ Claim # ____
Claims Adjustors Name ________________________ Driver/Owner ________________________
Have you retained an attorney? ( ) Yes ( ) No If yes attorney's name________________________
Were there any witnesses? ( ) Yes ( ) No,
If yes, please provide name(s) and contact info. __________________________________

Nature of Accident:

1. Date of Accident: _________ Time of Day _________ Weather Conditions________________
2. Were you: ( ) Driver ( ) Front Seat Passenger
   Passenger Back Seat: ( ) Left ( ) Middle or ( ) Right
3. Number of people in your vehicle? ________ Make/Model of vehicle?____________________
4. Number of people in other Vehicle(s)? _____ Make/Model of vehicle(s)?_________________
5. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on name of street ____
6. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on name of street ____
7. Were you stopped or still moving at the time of the accident?____________________________
8. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
9. What part of your car was hit?____
10. Were any vehicles in the accident totaled? ( ) Yes ( ) No.
    If yes, which vehicle(s) was totaled?____
11. Were you pushing on the brake pedal when the accident occurred? ( ) Yes ( ) No
12. Were you wearing a seat belt? ( ) Yes ( ) No. If yes were you wearing a Lap Belt ( ) Yes ( ) No and/or a Shoulder Belt ( ) Yes ( ) No ( )
13. What height was your headrest set at? top of headrest comes to: ( ) top of neck ( ) middle of head or ( ) top of head
14. Did you see the accident coming? ( ) Yes ( ) No,
    If yes, did you brace for the accident? ( ) Yes ( ) No
15. What direction was your head turned during the accident ? ( ) Forward ( ) Left ( ) Right ( ) Backwards
16. Did any part of your body hit anything within the car?____________________________________
17. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? ________
18. Were police notified? ( ) Yes ( ) No, If yes, was a report completed? ( ) Yes ( ) No
19. In your own words, please describe the accident: ____
    ____
    ____
20. Please describe any pain or symptoms:
    a. DURING the accident: ____
    b. IMMEDIATELY AFTER the accident: ____
    c. LATER THAT DAY: ____
    d. THE NEXT DAY: ____

West Portland Chiropractic
Dr. Matthew Todd DC
322 NW 5th Avenue, Suite 305, Portland, OR 97209
p: (207) 370-8516 f: (503) 227-0206
WestPortlandChiropractic@gmail.com

21. What are your PRESENT complaints and symptoms? ___________________________________
____
22. Did you go to the hospital after the accident? ( ) Yes ( ) No. If Yes Name____________________
23. Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No.
    If yes, please list doctor's name, address, and phone:________________________________
24. What type of treatment did you receive? ____
25. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
26. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Nervousness	☐ Pins & Needles in Arms
☐ Irritability	☐ Lights Bother Eyes	☐ Pins & Needles in Legs
☐ Numbness in Toes	☐ Head seems Too Heavy	☐ Loss of Memory
☐ Face Flushed	☐ Loss of Balance	☐ Loss of Taste
☐ Feet Cold	☐ Stomach Upset	☐ Fever
☐ Neck Pain	☐ Sleeping Problems	☐ Tension
☐ Chest Pain	☐ Depression	☐ Numbness in Fingers
☐ Shortness of Breath	☐ Fainting	☐ Ears Ring
☐ Buzzing in Ears	☐ Constipation	☐ Diarrhea
☐ Hands Cold	☐ Back Pain	☐ Cold Sweats
☐ Neck Stiff	☐ Loss of Smell	
☐ Dizziness		
☐ Fatigue		

Symptoms Other Than Above ____
27. Have you lost time from work as a result of this accident? ( ) Yes ( ) No.
    If yes, please complete this question.
    a. Last Day Worked: ____
    b. Type of Employment: ____
    c. Are you being compensated for time lost from work? ( ) Yes ( ) No.
        If yes, please state type of compensation you are receiving?____________________
        ____
28. Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No. If yes, please
    describe, in detail: ____
    ____
29. Did you have symptoms similar to your current injuries BEFORE THIS ACCIDENT?
    ( )Yes ( ) No, If yes, please describe in detail:______________________________
    ____
    ____
30. Have you ever been treated for a work injury, personal injury, or car accident before?
    ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accident(s) and injuries
    that occurred.____
    ____
    ____
    ____

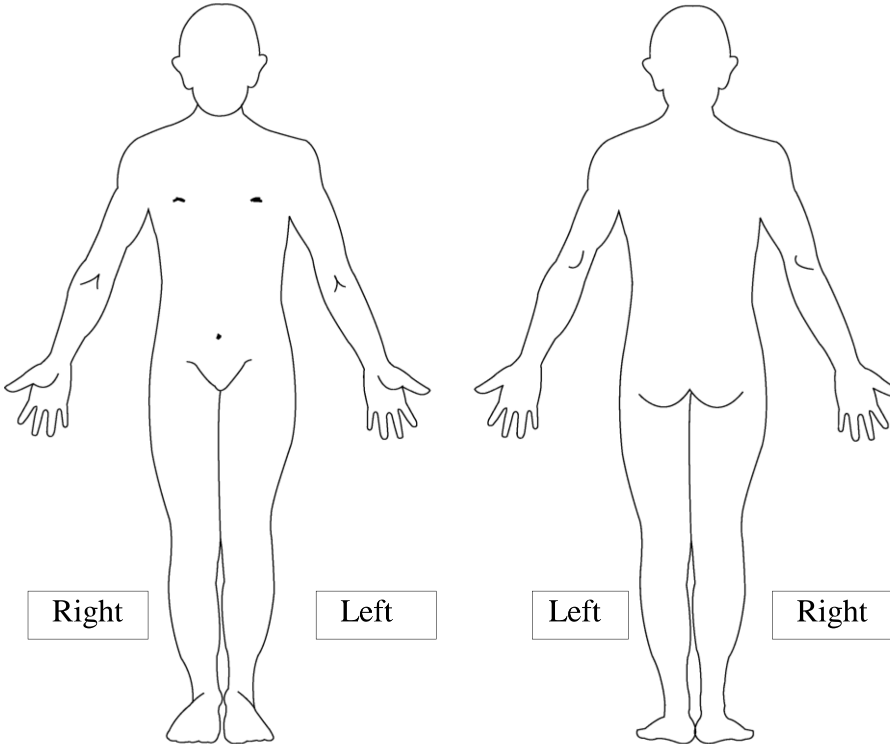
Patient Signature: ____________________________________ Date:_______________

West Portland Chiropractic

Dr. Matthew Todd DC
322 NW 5th Avenue, Suite 305, Portland, OR 97209
p: (207) 370-8516 f: (503) 227-0206
WestPortlandChiropractic@gmail.com

MARK ALL AREA(S) OF PAIN OR UNUSUAL FEELING WITH THE FOLLOWING SYMBOLS ON THE DIAGRAM BELOW

Numb	Tingling	Burning	Cramping/Spasms	Stabbing/Sharp	Achy/Dull
NNNN	TTTTT	BBBB	CCCCCC	SSSSSSSS	AAAA



Please mark on the pain scale from 0 to 10 the pain you feel with this condition.

Location of Pain?_______________

0 **10**
no pain **severe pain**

Location of Pain?_______________

0 **10**
no pain **severe pain**

Location of Pain?_______________

0 **10**
no pain **severe pain**

Patient Signature: ____ Date:_________________

West Portland Chiropractic
Dr. Matthew Todd DC
322 NW 5th Avenue, Suite 305, Portland, OR 97209
p: (207) 370-8516 f: (503) 227-0206
WestPortlandChiropractic@gmail.com

Informed Consent

I hereby request, authorize and consent:

West Portland Chiropractic
322 NW 5th Avenue, Suite 305
Portland, OR 97209

to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there is a very small risk of serious injury due to treatment (most research shows a risks of 1 in 1,000,000 to 1 in 3,000,000 chance of serious injury), including but not limited to fractures, disc injuries, and stroke. For comparison ibuprofen taken over a long period of time increases the risk of a stroke by almost three times. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. 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.

____

Print Patient name **D.O.B.**

____

Patient Signature or Parent/Guardian Signature if younger than 18

____

Print name of Parent or Guardian **D.O.B.**

____

Your Relationship to Patient

____

Date

West Portland Chiropractic
Dr. Matthew Todd DC
322 NW 5th Avenue, Suite 305, Portland, OR 97209
p: (207) 370-8516 f: (503) 227-0206
WestPortlandChiropractic@gmail.com

Patient Privacy Agreement Verification

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures that you will receive at your first appointment. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Notice of Privacy Practices for Protected Health Information for this office

____
Patient name **D.O.B.**

____
Patient Signature or Parent/Guardian Signature if younger than 18

____
Printed name of Parent or Guardian **D.O.B.**

____
Your Relationship to Patient

____
Date