NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

ACCIDENT INFORMATION FORM

Name_____ DOB_____ Date_____

Date of Accident_____

Your Insurance Information
Name of Policy Holder_____

Policy Holder's Insurance Company_____

Insurance Company Address_____

Claim's Adjuster Name_____ Adjuster phone #_____

Policy Number_____ Claim Number_____

Other Driver's Information
Name of the Other Driver_____

Other Driver's Insurance Company_____ Phone #_____

Attorney Information
Attorney Name and Phone #_____

Attorney Address_____

THIS FORM MUST BE COMPLETED AND RETURNED TO THE OFFICE OF NW FAMILY WELLNESS CENTER WITHIN 48 HOURS OF YOUR FIRST VISIT. IN ADDITION, AN APPLICATION FOR MEDICAL BENEFITS MUST BE FILLED OUT AND FILED WITH YOUR INSURANCE COMPANY TO ACTIVATE THIS CLAIM.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize NW Family Wellness Center to release my records in order to obtain payment on my account for services provided to me. I authorize payment for such services to be paid directly to NW Family Wellness Center. I understand that I am financially responsible for any charges not paid by my insurance carrier or attorney. If I do not file a completed application for medical benefits with my insurance company, I understand that I will be required to pay cash at the time of service for all care.

Signature_____ Date_____

NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

Name_____ DOB_____ Date_____

Date & Time of Accident_____

State how the accident happened_____

_____

_____

Where were you sitting? _____Driver _____Right front _____Right rear _____Left rear

Whose vehicle were you in?_____

Where were you facing on impact?_____

Were you aware of the impending impact?_____

Did you lose consciousness?_____ If so, how long?_____

Did your head hit the headrest?_____

Did the airbag deploy: _____ on the driver's side _____ on the passenger's side _____ not at all

Were you cut or bruised from the accident? Please describe_____

_____

Since your accident, have you experienced? Check those that apply:

_____ Headache

_____ Blurred Vision

_____ Dizziness

_____ Ache/pain in jaw

_____ Sore throat

_____ Pain on swallowing

_____ Trouble sleeping

NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

Name_____ DOB_____ Date_____

Accident History, page 2

What were your immediate symptoms? _____

_____

_____

What are your current symptoms? _____

_____

_____

Have you received any care for your injuries? If so, who was the provider? _____

_____

What type of care did you receive and for how long? _____

_____

_____

Please list any medication that you are taking as a result of this accident (over the counter and/or prescription):

_____

How often did you have any of the following **before** the accident?

	Never	Sometimes	Often	Always
Headache				
Ache/pain in lower back				
Ache/pain in mid-back				
Ache/pain in neck/shoulder				
Ache/pain in jaw				
Dizziness				
Trouble sleeping				

Additional Comments: _____

NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

NECK DISABILITY INDEX QUESTIONNAIRE

Name:_____ DOB:_____ Date:_____ Score:_____

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	SECTION 6 – Concentration A. I can concentrate fully when I want to with no difficulty. B. I can concentrate fully when I want to with slight difficulty. C. I have a fair degree of difficulty in concentrating when I want to. D. I have a lot of difficulty in concentrating when I want to. E. I have a great deal of difficulty in concentrating when I want to. F. I cannot concentrate at all.
SECTION 2 – Personal Care (Washing, Dressing, etc.) A. I can look after myself normally without causing extra pain. B. I can look after myself normally, but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self-care. F. I do not get dressed, I wash with difficulty and stay in bed.	SECTION 7 – Work A. I can do as much work as I want to. B. I can only do my usual work, but no more. C. I can do most of my usual work, but no more. D. I cannot do my usual work. E. I can hardly do any work at all. F. I cannot do any work at all.
SECTION 3 – Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it gives extra pain. C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E. I can lift very light weights. F. I cannot lift or carry anything at all.	SECTION 8 – Driving A. I can drive my car without any neck pain. B. I can drive my car as long as I want with slight pain in my neck. C. I can drive my car as long as I want with moderate pain in my neck. D. I cannot drive my car as long as I want because of moderate pain in my neck. E. I can hardly drive at all because of severe pain in my neck. F. I cannot drive my car at all.
SECTION 4 – Reading A. I can read as much as I want to with no pain in my neck. B. I can read as much as I want to with slight pain in my neck. C. I can read as much as I want to with moderate pain in my neck. D. I cannot read as much as I want because of moderate pain in my neck. E. I cannot read as much as I want because of severe pain in my neck. F. I cannot read at all.	SECTION 9 – Sleeping A. I have no trouble sleeping. B. My sleep is slightly disturbed (less than 1 hour sleepless). C. My sleep is mildly disturbed (1-2 hours sleepless). D. My sleep is moderately disturbed (2-3 hours sleepless). E. My sleep is greatly disturbed (3-4 hours sleepless). F. My sleep is completely disturbed (5-7 hours).
SECTION 5 – Headaches A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.	SECTION 10 – Recreation A. I am able to engage in all of my recreational activities with no neck pain at all. B. I am able to engage in all of my recreational activities with some pain in my neck. C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. D. I am able to engage in a few of my recreational activities because of pain in my neck. E. I can hardly do any recreational activities because of pain in my neck. F. I cannot do any recreational activities at all.

COMMENTS:_____

_____

_____

_____

Vernon H. Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physical Ther 1991:14:409-415

NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

OSWESTRY DISABILITY INDEX 2.0

Name:_____ DOB:_____ Date:_____ Score:_____

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.
Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

SECTION 1 – Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	SECTION 6 – Standing A. I can stand as long as I want without extra pain. B. I can stand as long as I want but it gives me extra pain. C. Pain prevents me from standing for more than 1 hour. D. Pain prevents me from standing for more than ½ hour. E. Pain prevents me from standing for more than 10 minutes. F. Pain prevents me from standing at all.
SECTION 2 – Personal Care (Washing, Dressing, etc.) A. I can look after myself normally without causing extra pain. B. I can look after myself normally, but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self-care. F. I do not get dressed, I wash with difficulty and stay in bed.	SECTION 7 – Sleeping A. My sleep is never disturbed by pain. B. My sleep is occasionally disturbed by pain. C. Because of pain I have less than 6 hours' sleep. D. Because of pain I have less than 4 hours' sleep. E. Because of pain I have less than 2 hours' sleep. F. Pain prevents me from sleeping at all.
SECTION 3 – Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it causes extra pain. C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E. I can only lift very light weights, at the most. F. I cannot lift or carry anything at all.	SECTION 8 – Sex Life (if applicable) A. My sex life is normal and causes me no extra pain. B. My sex life is normal, but causes some extra pain. C. My sex life is nearly normal but is very painful. D. My sex life is severely restricted by pain. E. My sex life is nearly absent because of pain. F. Pain prevents any sex life at all.
SECTION 4 – Walking A. Pain does not prevent me from walking any distance. B. Pain prevents me from walking more than one mile. C. Pain prevents me from walking more than ¼ mile. D. Pain prevents me from walking more than 100 yards. E. I can only walk while using a stick or crutches. F. I am in bed most of the time and have to crawl to the toilet.	SECTION 9 – Social Life A. My social life is normal and causes me no extra pain. B. My social life is normal, but increases the degree of pain. C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc. D. Pain has restricted my social life and I do not go out as often. E. Pain has restricted my social life to my home. F. I have no social life because of the pain.
SECTION 5 – Sitting A. I can sit in any chair as long as I like. B. I can only sit in my favorite chair as long as I like. C. Pain prevents me from sitting more than 1 hour. D. Pain prevents me from sitting more than ½ hour. E. Pain prevents me from sitting more than 10 minutes. F. Pain prevents me from sitting at all.	SECTION 10 – Traveling A. I can travel anywhere without pain. B. I can travel anywhere but gives extra pain. C. Pain is bad but I manage journeys over 2 hours. D. Pain restricts me to journeys of less than 1 hour. E. Pain restricts me to short necessary journeys under 30 minutes. F. Pain prevents me from traveling except to receive treatment.

COMMENTS:_____

_____

_____

_____

Roland M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 23(24): 3115-24.

NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay the debt owed an in consideration for receiving future care at or by the clinic and doctors whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the day_____ of_____, 20_____, to the full extent of the cost of treatment provided or to be provided to me by the Clinic.
I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect the Clinic. I hereby further give, grant, assign, and convey a legally enforceable interest and lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments, or verdict by which I may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the Clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration for the Clinic waiting for payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment, or verdict for which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic. I further understand and agree that the Clinic is not responsible for paying any of my attorney's fees and the Clinic does not agree to pay my attorney(s) any attorney's fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S INTEREST AT THE TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW THAT I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, CONVEYANCE, AND LIEN."

_____	_____	_____
Patient Name (Print)	Patient Signature	Date