DeMasi Wellness

DeMasi Chiropractic and Wellness Personal injury Questionnaire

Name_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____ Age:_____ Birthdate:_____

Your Ins. Co._____ Policy #_____

Agent's Name and Number:_____

Name on Policy (if other than self): _____ Policy #:_____

Responsible Party's Name:_____

Address:_____

Policy Holder's Name:_____ Policy #:_____

ATTORNEY

Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

NATURE OF ACCIDENT

1. Date of the accident_____.
2. Where were you employed at the time of the accident? _____.
3. What were your employment duties? **Clerical/Lift Lifting/ Heavy Lifting**.
4. Were you the **Driver/Passenger**?
5. Make Model and Year of the car you were in:_____.
6. Was the car **Moving/Stopped**?
7. What was the estimated speed of your car at impact? _____.
8. What part of your car was hit?_____.
9. What was the make and model of the bullet car? _____
10. What was the estimated speed of bullet car?_____.
11. What size was the bullet car compared to your car? **Half/Same/Double**.
12. What was the visibility **Clear/Raining/Snowing** and road conditions, **Wet/Dry/Under Construction**?
13. Were you braced for impact? **Y/N**.
14. Did you have your seatbelt on **Y/N**?
15. Did you suffer bruising from the seatbelt **Y/N**?
16. What position was the head rest? **Even with top of head / Even with bottom of head / Even with neck.**
17. Where were your hands positioned on steering wheel? _____.
18. Did you lose consciousness **Y/N**?
19. Did the air bags deploy **Y/N**?
20. Did the seat break **Y/N**?
21. Were any objects thrown around in the vehicle? _____.
22. Did any part of your body strike the inside of the car?_____.
23. Where the brakes applied **Y/N**?

24. Did the police arrive **Y/N**?
25. Did anyone receive a ticket or citation **Y/N**?
26. Did EMT arrive on scene **Y/N**?
27. Did the EMT take you to the hospital **Y/N**?
28. What aid did you use after the collision ? _____.
29. What aid are you using now? _____.
30. How did your vehicle leave the scene? **Towed/Driven.**
31. How did the other vehicle leave the scene? **Towed/Driven.**
32. Estimated damage to your vehicle $_____.

HEALTH HISTORY

Are you currently taking any medications?_____.
List any prior surgeries and approximate dates._____
Have you had any prior treatment **Y/N**? If so, please explain_____.
Have you experienced any prior collisions **Y/N**? If so, please explain_____.
CHIEF COMPLAINT
Please complete a section for each area that is in pain

1._____. How often are you experiencing this pain **0/25/50/75/100** % of the day? On a scale of 0 (no pain) to 10 (worst pain), how would you rate your pain when it is at its worst _____, and at its best _____. When did the pain begin, **Prior to the collision/immediately after the collision/hours after/the next day**? Is the pain currently getting **Better/Worse/Same**? Are there any specific actions or positions that **INCREASE** the pain? _____. Are there any specific actions or positions that **DECREASE** the pain? _____. What type of pain are you experiencing? **Dull/Achey/Sharp/Stabbing/Numbness.** Do you have any numbness or tingling in your arms/hands/legs/feet? If so, explain_____. What time of the day is the pain at its worst? **Morning/Noon/Afternoon/After Work/ Before Bed.**

2. _____. How often are you experiencing this pain **0/25/50/75/100** % of the day? On a scale of 0 (no pain) to 10 (worst pain), how would you rate your pain when it is at its worst _____, and at its best _____. When did the pain begin, **Prior to the collision/immediately after the collision/hours after/the next day**? Is the pain currently getting **Better/Worse/Same**? Are there any specific actions or positions that **INCREASE** the pain? _____. Are there any specific actions or positions that **DECREASE** the pain? _____. What type of pain are you experiencing? **Dull/Achey/Sharp/Stabbing/Numbness.** Do you have any numbness or tingling in your arms/hands/legs/feet? If so, explain_____. What time of the day is the pain at its worst? **Morning/Noon/Afternoon/After Work/ Before Bed.**

3._____. How often are you experiencing this pain **0/25/50/75/100** % of the day? On a scale of 0 (no pain) to 10 (worst pain), how would you rate your pain when it is at its worst _____, and at its best _____. When did the pain begin, **Prior to the collision/immediately after the collision/hours after/the next day**? Is the pain currently getting **Better/Worse/Same**? Are there any specific actions or positions that **INCREASE** the pain? _____. Are there any specific actions or positions that **DECREASE** the pain? _____. What type of pain are you experiencing? **Dull/Achy/Sharp/Stabbing/Numbness.** Do you have any numbness or tingling in your arms/hands/legs/feet? If so, explain_____. What time of the day is the pain at its worst? **Morning/Noon/Afternoon/After Work/ Before Bed.**

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PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

DeMasi Wellness

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

DeMasi Wellness

NOTICE OF DOCTOR'S LIEN

Patient:_____

Date of Accident:_____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis., etc. f myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that his agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated_____ _____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated_____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor:_____

Address:_____

DeMasi Wellness

FOR OFFICE USE ONLY

Height Weight BP HR

Range Of Motion

Cervical / Lumbar / Shoulder / Elbow / Hand / Hip / Knee / Ankle

	Severe	Moderate	Mild	Normal	Painful
Flexion					
Extension					
Left Rotation /					
Right Rotation					
Left Lateral Flexion / Abduction					
Right Lateral Flexion / Adduction					

MMT

Muscle Tested	Graded	Pain
	/ 5	
	/ 5	

Ortho Tests

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date:_____ /_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- **None**
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:
- **None**
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching *(around the eyes)*
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:
- **None**
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection*(s)*
- Ear Pain
- Fainting
- Headaches
- Head Injury *(history of)*
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea *(runny nose)*
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus *(ringing in the ears)*
- TMJ Disorder

Cardiovascular:
- **None**
- Angina *(chest pain or discomfort)*
- Chest Pain
- Claudication *(leg pain or achiness)*
- Heart Murmur
- Heart Problems
- Orthopnea *(difficulty breathing while lying)*
- Palpitations *(irregular or forceful heart beat)*
- Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- Shortness of Breath
- Swelling of Leg*(s)*
- Ulcers
- Varicose Veins

Gastrointestinal:
- **None**
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice *(yellowing of the skin)*
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber *(quality)*
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:
- **None**
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:
- **None**
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:
- **None**
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:
- **None**
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:
- **None**
- Anaphylaxis *(history of)*
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:
- **None**
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion*(s)*
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:
- **None**
- Anhedonia *(inability to experience joy or enjoy life)*
- Anxiety
- Appetite Changes
- Behavioral Change*(s)*
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change*(s)*

Female:
- **None**
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Male:
- **None**
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

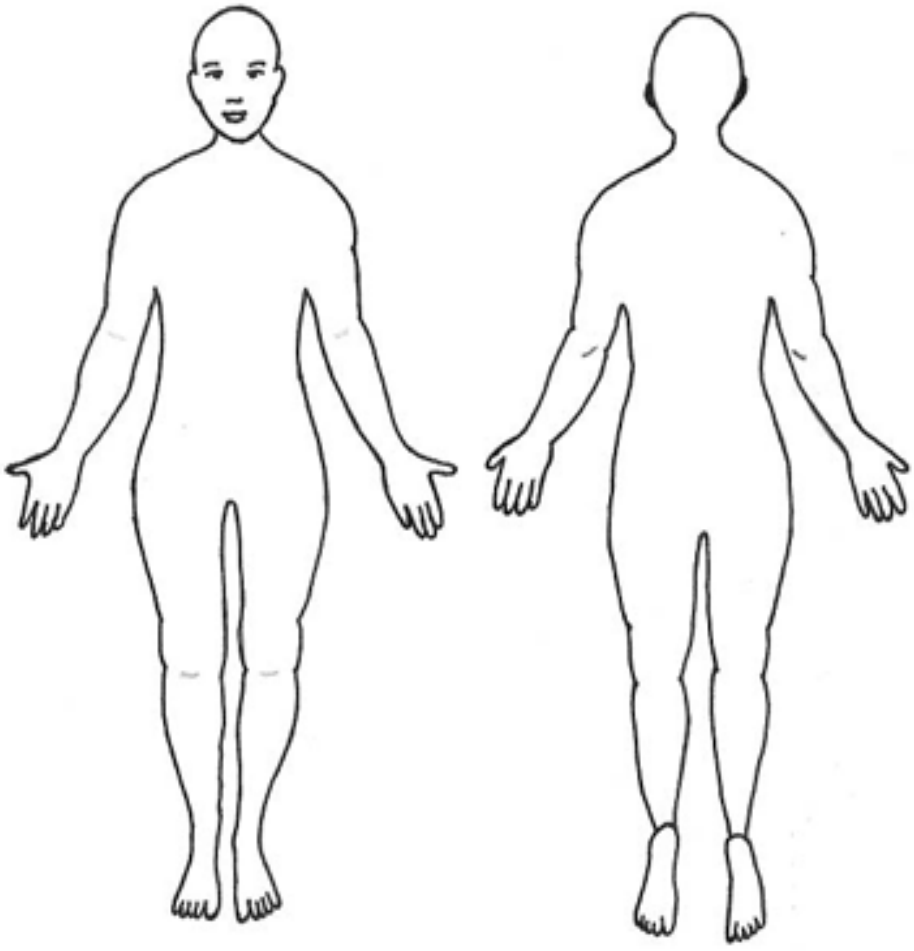
Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ _____

Doctor Signature Date

Name: _____ Date: _____



Please mark an X on any area since your last exam that you have had any pain, tingling, numbness or abnormal sensation.

1. Have you had any change in medical history since your last visit? Example: Change in MEDs or medical procedures...etc_____

_____

2. Any major or minor traumas since your last visit?_____

_____