SICILIA
CHIROPRACTIC

DR. RAYMOND SICILIA
611 W. GARLAND AVE.
SPOKANE, WA 99205
PH: (509)489-2883 FAX: (509)487-0898

ACCIDENT BILLING INFORMATION

PATIENT NAME: _____
LAST NAME FIRST NAME

DATE OF BIRTH: _____

Date of Accident: _____/_____/_____ Which State did this occur? _____

Do you have an attorney representing you?

☐ NO ☐ YES; Attorney Name: _____; Ph#: _____

CLAIM/INSURANCE INFORMATION

******IMPORTANT NOTICE******

Regardless of who is at fault in an auto accident, you should contact YOUR Auto Insurance carrier regarding your accident to discuss PERSONAL INJURY PROTECTION (PIP) benefits.

PIP Billing Information

Your Auto Insurance Company: _____

Claim #: _____ Policy Holder Name: _____

Adjuster Name: _____ Adjuster Ph#: _____

If there is no PERSONAL INJURY PROTECTION (PIP) on your auto insurance coverage, we will need to have the information for the party at fault AND your medical insurance.

3rd Party (Other Driver's) Billing Information

3rd Party Auto Insurance Company: _____

Claim #: _____ Polcy Holder Name: _____

Is the PolicyHolder the Driver? Yes No

Adjuster's Name: _____ Adjuster Ph#: _____

Your Medical Insurance Information (enter information here or provide copy of card)

Primary Insurance Co: _____

Member ID# _____ Group #: _____

The information provided is true and correct to the best of my knowledge and I hereby authorize Inland Wellness dba Sicilia Chiropractic to provide me with chiropractic care in accordance with WA State's statutes. I authorize payments of all medical benefits to Inland Wellness dba Sicilia Chiropractic for services performed and billed.

_____ _____

Patient or Guardian Signature Date

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Auto Accident Mechanism of Injury Form

Patient Name: _____ Date of Birth: _____

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**
What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**
If "Driver", were your hands on the steering wheel? **Both / Left / Right**

What was the year, make and model of vehicle were you in? _____
Direction of Impact: **Front / Back / Left / Right / Other**: _____
What was the year, make and model of the other vehicle? _____
What was the approximate speed of **your vehicle** when the accident occurred? _____ mph
What was the approximate speed of the **other vehicle** when the accident occurred? _____ mph
Did the airbags deploy? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**
If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other**: _____

In relation to the back of your head, was your headrest set: **Low / Middle / High**
Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**
Where was your head facing at the time of impact? **Straight Ahead/ Left/ Right/ Behind/ Inclined**
Were you leaning forward at the time of impact? **Yes / No**
Did you feel pain immediately after the accident? **Yes / No** If yes, where? _____

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other**: _____

Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no
   a. What body parts:
   _____

B. Visual Disturbance: yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
   % of time: ____ % of time: ____ % of time: ____ % of time: ____

C. Dizziness: yes/no % of time: ____

D. Anxiety/Depression: yes/no % of time: ____

E. Difficulty Sleeping: yes/no % of time: ____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other**: _____

What other doctors have you seen as a result of this injury? _____

_____

_____

_____ _____

Patient Signature Date

NEW PATIENT HISTORY FORM

Patient Name: _____ **Date:** _____

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
    - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

Symptom 2 _____ ☐ Does Not Apply

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Symptom 3 _____ ☐ Does Not Apply

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____