CAD Injury History Form

General information:

Patient' name: ____________________
Today's date: ____________________
Date of injury: ____________________
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____ Years _______
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: ____________________
☐ Unemployed
Currently: ____________________
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): ____________________

Fractures (dates and residuals): ____________________

Serious illness (dates and residuals): ____________________

Workers' comp. injuries (date, TX, awards, residuals): ____________________

Personal Injuries (date, TX, awards, residuals):

Sports or other injuries to head, neck, or back:

Past medical history (cont'd)

Any prior HX of current complaints:
1. ____________________
2. ____________________
3. ____________________

Prior TX by DC for these:
1. ____________________
2. ____________________
3. ____________________

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

Injury history. General:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other __________
Vehicle driven by: ____________________
Your vehicle (year, make, model): ____________________
Your estimated speed at moment of crash: ________
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): ____________________
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other __________
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean
Other ____________________
Head position: ☐ Forward ☐ Left ____°
☐ Right ____° ☐ Up ____° ☐ Down ____°

Injury history. General: (cont'd)

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No
Crash description: ____________________
____
____
____
____
____
____
____
____

Crash diagram:

Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe____________________
Did vehicle strike any objects after crash?
If yes, describe____________________
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long?____________________
Estimated property damage to your vehicle:
$ ____________________
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Paresthesia(s)
If yes, where?____________________
☐ Extremity pain. If yes, where?____________________
☐ Back pain
When did SX first appear? ☐ Immediately
(describe which SX)____________________ hr afterward
Where did you go after crash? ☐ Home ☐ Work ☐ Hospital:
Mode of transportation ____________________
Pvt. doctor:____________________

Emergency department:

Radiographs: ☐ Yes ☐ No
Body parts imaged____________________
Results____________________
Lab work ☐ Yes ☐ No ____________________
☐ Cervical collar ☐ Ice
Medications:____________________
Other: ____________________
Follow-up instructions: ☐ None____________________

Treatment history:

1. Dr.: ____________________
Specialty:__________ Date first seen: __________
Referred by:__________ TX type: __________
TX frequency:__________ TX duration: __________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐ No
Notes: ____________________
____

2. Dr.: ____________________
Specialty:__________ Date first seen:__________
Referred by:__________ TX type:__________
TX frequency:__________ TX duration:__________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐ No
Notes: ____________________
____

Treatment history: (cont'd)

3. Dr.: ______________________
Specialty: __________ Date first seen: ________
Referred by: __________ TX type: ________
TX frequency: __________ TX duration: ________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______________________
Special tests: ______________________
Referred to: ______________________
Did TX help? ☐ Yes ☐ No
Notes: ______________________

4. Dr.: ______________________
Specialty: __________ Date first seen: ________
Referred by: __________ TX type: ________
TX frequency: __________ TX duration: ________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______________________
Special tests: ______________________
Referred to: ______________________
Did TX help? ☐ Yes ☐ No
Notes: ______________________

5. Dr.: ______________________
Specialty: __________ Date first seen: ________
Referred by: __________ TX type: ________
TX frequency: __________ TX duration: ________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______________________
Special tests: ______________________
Referred to: ______________________
Did TX help? ☐ Yes ☐ No
Notes: ______________________

6. Dr.: ______________________
Specialty: __________ Date first seen: ________
Referred by: __________ TX type: ________
TX frequency: __________ TX duration: ________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______________________
Special tests: ______________________
Referred to: ______________________
Did TX help? ☐ Yes ☐ No
Notes: ______________________

Original chief complaints (if injury was not recent):

1. Body part/system: ________
Onset: ________
Provocative: ________
Palliative: ________
Quality: ________
Radiation: ________
Severity (1-4): ________
Temporal: ________

2. Body part/system: ________
Onset: ________
Provocative: ________
Palliative: ________
Quality: ________
Radiation: ________
Severity (1-4): ________
Temporal: ________

3. Body part/system: ________
Onset: ________
Provocative: ________
Palliative: ________
Quality: ________
Radiation: ________
Severity (1-4): ________
Temporal: ________

4. Body part/system: ________
Onset: ________
Provocative: ________
Palliative: ________
Quality: ________
Radiation: ________
Severity (1-4): ________
Temporal: ________

5. Body part/system: ________
Onset: ________
Provocative: ________
Palliative: ________
Quality: ________
Radiation: ________
Severity (1-4): ________
Temporal: ________

Current chief complaints:

1. Body part/system: ____________
Onset: ____________
Provocative: ____________
Palliative: ____________
Quality: ____________
Radiation: ____________
Severity (1-4): ____________
Temporal: ____________

2. Body part/system: ____________
Onset: ____________
Provocative: ____________
Palliative: ____________
Quality: ____________
Radiation: ____________
Severity (1-4): ____________
Temporal: ____________

3. Body part/system: ____________
Onset: ____________
Provocative: ____________
Palliative: ____________
Quality: ____________
Radiation: ____________
Severity (1-4): ____________
Temporal: ____________

4. Body part/system: ____________
Onset: ____________
Provocative: ____________
Palliative: ____________
Quality: ____________
Radiation: ____________
Severity (1-4): ____________
Temporal: ____________

5. Body part/system: ____________
Onset: ____________
Provocative: ____________
Palliative: ____________
Quality: ____________
Radiation: ____________
Severity (1-4): ____________
Temporal: ____________

Self assessment as of today: % improved (list for separate areas)

Request records:

☐ 1. Request radiographs from: ____________

☐ 2. Request records from: ____________

☐ 3. Request copy of police report.

Referral:

☐ For: ____________
☐ To: ____________

Tests to order:

☐ Radiographs: ____________
☐ Tomograms: ____________
☐ CT: ____________
Area(s): ____________
☐ MRI: ____________
Area(s): ____________
☐ MRA: ____________
Area(s): ____________
☐ Scintigraphy/SPECT: ____________
Area(s): ____________
☐ Videofluoroscopy: ____________
Area(s): ____________
☐ EMG/NCV: ____________
Root level/nerve(s): ____________
☐ SEP: ____________
Root level/nerve(s): ____________
☐ Other electrodiagnostic test(s): ____________
☐ Ultrasound: ____________
Area(s): ____________

Action taken on this visit:

☐ Exam/TX: ____________

☐ Place on disability: ____________
☐ Work restriction: ____________
☐ Referral: ____________
☐ Brace/collar: ____________
☐ Home traction device: ____________
☐ NEXERCICER: ____________
☐ Supplements: ____________
☐ Other: ____________

2980 S Jones Blvd, Ste. F, Las Vegas, NV 89146
Clinic (702)256-2225 Fax (702)254-0180
Billing (702) 367-4355

Waiver of Private Insurance Benefits

I understand that by utilizing my private insurance carrier, the services rendered to me by Canyon Lake Neck and Back may be limited and/or exhausted. It is my desire to preserve my private insurance benefits for any future treatment I may require, which is unrelated to this personal injury claim. I have decided to waive my private insurance benefits and agree to pay for the services rendered to me at Canyon Lake Neck and Back as outlined in the "Doctor's Lien" which I have signed.

If there is an automobile insurance policy that has "medical payment" coverage which can be used for my treatment, I agree that all medical payment monies from said automobile insurance company should be used to satisfy any outstanding balance with Canyon Lake Neck and Back and checks should be payable and sent directly to Canyon Lake Neck and Back. If needed, I also authorize Canyon Lake Neck and Back to sign my name in the event a check for services rendered is mad out to me or both parties and I cannot be reached. This agreement will supersede all other agreements, contractual or otherwise, including but not limited to agreements with attorney or other agencies or agents.

I have requested and do hereby request that the above provide health care services to me for injuries received. I hereby give a lien to said doctor on any settlement, claim, and judgment. Or my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing for services rendered to me and to withhold such sums for such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

I further agree never to rescind this document and that recession will not be honored by my attorney. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by this office for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

Patient's Signature	Witnessed
Printed Name	Printed Name
Date	Date

2980 S Jones Blvd, Ste. F, Las Vegas, NV 89146
Clinic (702)256-2225 Fax (702)254-0180
Billing (702) 367-4355

Personal Injury Cases

Label for Patient Attorney Information

Med-Pay Coverage

☐ Yes ☐ No Coverage

If yes please list policy amount: $___________._____

Insurance Company Name: ______________________________

Insurance Company Phone No. ______________________________

Billing Address: ______________________________

Claim #: ______________________________

Agent/Adjuster ______________________________

Policy Holder: ______________________________

Policy No. ______________________________

For Office Use Only

☐ Lien sent to the attorney (Date: ___________________)

☐ Patient has no med-pay & has not acquired an attorney to date.

☐ Patient has not reported accident to insurance company to date.

Canyon Lake
Neck & Back Clinic
2980 S Jones Blvd, Ste. F, Las Vegas, NV 89146
Clinic (702)256-2225 Fax (702)254-0180
Billing (702) 367-4355

CANYON LAKE NECK & BACK CLINIC LIEN

Patient's Attorney/Insurance/
3rd Party Guarantor Label

Patient Name: ______________________________

S.S. #: ______________________________

D.O.I.: ______________________________

I do hereby authorize Canyon Lake Neck & Back Clinic to furnish the above attorney, insurance carrier and/or 3rd Party Guarantor with all records regarding the accident/injury for which I am receiving or have received treatment.

I hereby authorize and direct you, my attorney, insurance carrier and or 3rd Party Guarantor, to pay directly to Canyon Lake Neck & Back Clinic such sums as may be due and owing for services rendered me both by reason of this accident and by reason of any other bills that are due and to withhold such sums from any settlement, judgement or verdict which may be paid to you, my attorney, to myself or to another individual on my behalf, and/or by you the insurance carrier, as may be necessary to adequately protect and clear my account with Canyon Lake Neck & Back Clinic. I hereby give a Lien on my case to Canyon Lake Neck & Back Clinic against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself or to another individual on my behalf, by you the insurance carrier and/or the 3rd Party Guarantor, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Canyon Lake Neck & Back Clinic for all bills submitted for service rendered me and that this agreement is made solely for additional protection and in consideration of awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. Patient further understands and accepts financial responsibility for payment of all accounts with the Canyon Lake Neck & Back. Patient understands that the legal settlement may pay all, part, or none of Patient's account(s) and the Patient is responsible for complete payment of all account(s)

Interest on this lien is 18% per annum, commencing 30 days from the date of payment of settlement, judgement or award relating to services rendered by Canyon Lake Neck & Back Clinic.

I waive the Statute of Limitation regarding Canyon Lake Neck & Back Clinic's right to recover.

It is understood and agreed that a copy of this lien shall have the same force and effect as the original.

Date:_______________ **Patient's Signature:**______________________________

The undersigned attorney of record, insurance carrier and/or 3rd Party Guarantor for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict, as may be necessary to adequately protect Canyon Lake Neck & Back Clinic and to disperse such sums to said clinic.

Date: ______________Attorney/Insurance Carrier/3rd Party Signature: ____________________

*******Please date, sign and return original to: Canyon Lake Neck & Back Clinic**
2980 S. Jones Blvd, Suite F
Las Vegas, NV 89146
FAX: (702) 254-0180