Medical Rehab
Accident Injury Center

ACCIDENT QUESTIONNAIRE
Cuestionario de Accidente

NAME _____ **DATE OF ACCIDENT** _____
NOMBRE **FECHA DEL ACCIDENTE**

1. What kind of car were you in?
¿En qué tipo de vehiculo estaba?
___**Compact**
Compacto
___**Mid-size**
De tamaño medio
___**Full size**
De tamaño completo
___**SUV**
SUV
___**Mini-van**
Mini-van
___**Pick-Up Truck**
Camioneta
___**Bus**
Autobús

2. What was the other vehicle?
¿Que tipo era el otro vehiculo?
___**Compact**
Compacto
___**Mid-size**
De tamaño medio
___**Full size**
De tamaño completo
___**SUV**
SUV
___**Mini-van**
Mini-van
___**Pick-Up Truck**
Camioneta
___**Bus**
Autobús

3. Did you hit anything else after the first impact?
¿Tuvo un Segundo impacto?
___**Yes/Si** ___**No**
___**Another vehicle**
Otro vehículo
___**Other**/Otro_____

_____

_____

4. At the time of the crash what was your vehicle doing?
En el momento del accidente que estaba haciendo su vehículo?
___**Stopped at a stop sign/red light**
Detenido en una señal de alto/luz roja
___**Stopped in traffic or stopped for another reason**
Detenido en el tráfico o interrumpido por cualquier otro motivo
___**Moving with traffic**
Moviendose con el tráfico
___**Crossing an intersection**
Cruzando una intersección
___**Turning**
Girando
___**Other**/Otro _____

5. How was your vehicle hit?
¿Donde recibio el impacto su vehiculo?
___**From behind/rear impact**
De atrás/impacto trasero
___**From the front/front impact**
De la parte frontal/de impacto frontal
___**From the side/side impact**
Impacto lateral
___**Other**/Otro _____
_____

6. What was the weather like when your crash happened?
¿Como estaba el clima cuando recibio el impacto?
___**Raining or recently rained**
Lloviendo o que llovio recientemente
___**Misting or recently misty**
Con neblina
___**Dry**
Seco

7. What was the street condition?
¿Cuál era el estado de la calle?
___**Wet/slick**
Mojado/resbaloso
___**Dry**
Seco

8. **Where were you located in the vehicle?**
¿En que lugar se encontraba en el coche?

___ **Driver's seat**
Conductor
___ **Front seat passenger**
Asiento delantero
___ **Back seat - driver's side**
Asiento trasero del lado del conductor
___ **Back seat - middle**
Asiento trasero en el medio
___ **Back seat - passenger's side**
Asiento trasero del pasajero
___ **Third row of SUV mini-van**
Tercera fila de SUV o mini-van
___ **Rear-facing child safety seat**
El asiento infantil viendo hacia atras
___ **Forward-facing child safety seat**
El asiento infantil viendo hacia enfrente
___ **Child booster seat**
Asiento elevado para ninos

9. **Did the airbag deploy?**
¿Se abrieron las bolsas de aire?
___**Yes/Si** ___**No**

10. **What was your head position?**
¿Cual fue la posicion de su cabeza?
___**Facing forward**
Mirando hacia en frente
___**Turned to right or left**
De lado
___**Looking up or down**
Mirando arriba o abajo

11. **Were you wearing a seat belt?**
¿Estaba usando un cinturón de seguridad?
___**Yes/Si** ___**No**
What kind of seat belt were you wearing?
¿Qué tipo de cinturón de seguridad estaba usando?
___**Lap/Shoulder**
Cintura/hombro
___**Shoulder only**
Sólo hombro
___**Lap only**
Sólo cintura

12. **Did your head hit anything?**
¿Golpeo su cabeza en algo?
___**Yes/Si** ___**No**
If yes what hit your head?
Si es asi ¿Qué golpeo su cabeza?
___ **Head restraint**
Cabecera del asiento
___**Steering Wheel**
Volante/Timon
___**Windshield**
Parabrisas
___**Window**
Ventana
___ **Dashboard**
Tablero
___**Do not remember**
No recuerdo

13. **Did you go to a hospital or doctor after the accident?**
¿Visito un hospital o medico despues del accidente?
___**Yes/Si** ___**No**
What hospital/doctor? _____
¿Qué hospital/médico?_____

DOCTOR'S USE ONLY – Solamente para uso del Medico

_____

_____

_____

_____

_____

Medical Rehab
Accident Injury Center

SYMPTOMS
SINTOMAS

NAME _____ **DATE OF ACCIDENT**_____
NOMBRE **FECHA DEL ACCIDENTE**

INSTRUCTIONS: Check any symptom you have felt at any time since your car accident
INSTRUCCIONES : Marque cualquier sintoma que haya sentido en algun momento desde su accidente automovilistico.

1. CUTS OR BRUISES - CORTADURAS O HEMATOMAS (MORETÓN)

___**Head or face**
Cabeza o la cara
___**Neck**
Cuello
___**Arms**
Brazos
___**Legs**
Piernas
___**Seat belt bruise or chest pain from seat belt**
Hematomas (moretón) por el cinturón de seguridad o dolor en el pecho del cinturón de seguridad
___**Other cuts or bruises**
Otros cortes o hematomas (moretón)_____

2. HEAD INJURIES - HERIDAS EN LA CABEZA

___**Were you knocked out or unconscious?**
¿Perdio la consciencia?
___**Headaches**
Dolor de cabeza
___**Dizziness**
Mareo
___**Difficulty walking**
Dificultad para caminar
___**Balance problems**
Problemas de equilibrio
___**Confused**
Confusion
___**Sensitive to noise**
Sensibildad al ruido
___**Sensitive to light**
Sensiblildad a la luz
___**Trouble concentrating**
Dificultad para concentrarse
___**Trouble remembering**
Problemas para recordar
___**Trouble speaking**
Dificultad para hablar
___**Tired/ Fatigued**
Cansancio/Fatigado
___**Change in appetite**
Cambio en apetito
___**Sleeping more or less than usual**
Duerme más o menos de lo usual
___**Vision problems: blurry/double vision**
Problemas de la vista: borrosa/visión doble
___**Trouble reading/writing**
Dificultad para leer/escribir
___**Nausea/Vomiting**
Náusea/Vómito
___**Depressed/Sad**
Deprimido/Triste
___**Anxious/Nervous**
Ancioso/Nervioso
___**Angry/Agitated**
Enojado/Agitado

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3. JAW PROBLEMS - MANDIBULA PROBLEMAS

___**Jaw pain**
Dolor en la mandíbula

___**Clicking**
Hace clic

___**Pain while chewing**
Dolor al masticar

___**Pain while talking**
Dolor mientras habla

___**Pain while yawning**
Dolor al bostezar

___**Pain while moving jaw from side to side**
Dolor mientras mueve la mandíbula a los lados

4. NECK - CUELLO

___**Neck pain** ___**Right side** ___**Left side** ___**Both sides**
Dolor de cuello ___ lado derecho ___ lado izquierdo ___ ambos lados

___**Pain radiating into the RIGHT shoulder**
Dolor que va hacia el hombro derecho

___**Pain radiating into the LEFT shoulder**
Dolor que va hacia el hombro izquierdo

___**Popping/clicking in neck**
Estallo/clic en el cuello

5. BACK- ESPALDA

___**Upper back pain** ___**Right side** ___**Left side** ___**Both sides**
Dolor de espalda arriba ___ lado derecho ___ lado izquierdo ___ ambos lados

___**Mid-back pain** ___**Right side** ___**Left side** ___**Both sides**
Dolor de espalda media ___ lado derecho ___ lado izquierdo ___ ambos lados

___**Low back pain** ___**Right side** ___**Left side** ___**Both sides**
Dolor de espalda baja ___ lado derecho ___ lado izquierdo ___ ambos lados

___**Pain radiating into the RIGHT hip/leg**
Dolor que va hacia la cadera/pierna derecha

___**Pain radiating into the LEFT hip/leg**
Dolor que va hacia la cadera/pierna izquierda

6. EXTREMITIES - EXTREMIDADES

___**Right shoulder** Hombro derecho	___**Right wrist** Muñeca derecha	___**Right hip** Cadera derecha	___**Right leg/ankle** Pierna derecha/tobillo
___**Left shoulder** Hombro izquierdo	___**Left wrist** Muñeca izquierda	___**Left hip** Cadera izquierda	___**Left leg/ankle** Pierna izquierda/tobillo
___**Right elbow** Codo derecho	___**Right hand** Mano derecha	___**Right knee** Rodilla derecha	___**Right foot** Pie derecho
___**Left elbow** Codo izquierdo	___**Left hand** Mano izquierda	___**Left knee** Rodilla izquierda	___**Left foot** Pie izquierdo

7. NUMBNESS/TINGLING - ADORMECIMIENTO/HORMIGUEO

Have you experienced any numbness or tingling since the motor vehicle accident? __Yes/Si __No
¿Ha experimentado adormecimiento o hormigueo despues de su accidente de carro?

INFORMED CONSENT TO TREAT

TO THE PATIENT: Please read this entire document prior to signing it. You have a right to be informed about your condition, the recommended chiropractic treatment and the potential risks involved with the recommended treatment. It is important that you understand the information contained in this document. Please ask questions before signing if there is a topic that you do not understand and we will be pleased to explain it.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment of your condition, you are consenting to the following procedures:

-Palpation	-Vital Sign Testing	-Range of Motion Testing
-Orthopedic Testing	-Basic Neurological Testing	-Muscle Strength Testing
-Radiographic Studies	-Hot/Cold Therapy	-Ultrasound Therapy
-Electrical Stimulation	-Mechanical Traction Therapy	-Massage
-Spinal Manipulative Therapy		

The Nature of the Chiropractic Adjustment

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/ or other licensed Doctors of Chiropractic working at this clinic or office. A chiropractic treatment may consist of the Doctor of Chiropractic using a mechanical instrument or his/her hands upon your body in such a way as to produce movement of your joints. This may cause an audible "pop" or "click" similar to when you "crack" your knuckles and you may also feel a sense of movement.

The Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic treatment and therapy. These complications include, but are not limited to: fracture (broken bones), dislocations, muscle strain, costovertebral strains and/or separations, intervertebral disc injury, cervical myelopathy and burns. Some patients may experience stiffness and/or soreness following the first few days of treatment. Certain types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including arterial dissection (stroke). The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform him/her.

The Probability of Those Risks Occurring

Fractures are a rare occurrence and generally result from some underlying weakness of the bone, which we check for during history taking, examination and radiographic studies (x-ray). Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Other Treatment Options:

Other treatment options for your condition may include:

- Rest and over-the-counter medications (analgesics, etc.)
- Medical care including prescription medications (pain-relievers, muscle relaxants and/or anti-inflammatory medications, etc.)
- Physical Therapy
- Hospitalization
- Surgery

If you choose to use one of the above "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician before proceeding.

The Risks to Remaining Untreated

Remaining untreated may allow for the formation of adhesions and reduced joint mobility, potentially setting up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer treatment has been postponed.

CONSENT TO TREAT (MINOR)

I hereby request and authorize Michael D. Haydel, D.C. and associates to perform diagnostic tests and render chiropractic treatment and/or other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic studies at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above information regarding chiropractic adjustments and related treatment. I have discussed it with either Michael D. Haydel, D.C. or one of his associates and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Signature of Parent or Guardian (if a minor): _____

ITCNO, LLC and ITCLA, LLC DISCLOSURE

Today's Date: _____

DISCLOSURE OF FINANCIAL INTEREST

Louisiana law requires physicians and other healthcare providers to make certain disclosures to a patient when they refer a patient to another healthcare provider or facility in which the physician has a significant financial interest. I am referring you, or the named patient for whom you are a legal representative to: Injury Treatment Center New Orleans (3714 Airline Dr., Metairie, LA 70001) or Injury Treatment Center of Louisiana (15814 Professional Plaza Dr., Hammond, LA 70403)

To obtain the following health care services, products, or items: Pain Evaluations, Interventional Treatments and Follow up Care. I, Dr. Michael D. Haydel, have a significant financial interest in the healthcare provider to whom we are referring you.

PATIENT ACKNOWLEGEMENT

I, the below named patient, or legal representative, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

_____ _____

(Print Patient's Name) (Signature of Patient or Patient's Representative)

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information you will be given a copy of the signed form, upon request

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, DHH may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

- ✓ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, DHH will use and disclose your health information as you have authorized on the signed authorization form.

- ✓ You may be required to sign an authorization before receiving research-related treatment.

- ✓ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by DHH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to DHH.

- ✓ You may cancel an authorization in writing at any time. DHH can not take back any uses or disclosures already made before an authorization was cancelled.

- ✓ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by DHH privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is: State of Louisiana, Department of Health and Hospitals, Office of Secretary, *Privacy Office, P.O. Box 629, Baton Rouge, LA 70821-0629*. Phone: 1-877-559-9664. E-mail: privacy-bhsf@la.gov

Louisiana Department of Health and Hospitals

Authorization to Release or Obtain Health Information (including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: Medical Rehab Accident Injury Center

Mailing Address: 1100 N. Causeway Blvd.

City, State, Zip Code: Metairie, LA 70001

Relationship: Healthcare Provider Telephone Number: 504-832-1032

☐ **RELEASE Information TO** or ☑ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☑ Further Medical Care ☐ Personal ☑ Legal Investigation or Action

☐ Changing Physicians ☐ Research related treatment

☑ Creating health information for disclosure to a third party.

☐ Other: (Specify)_____

I authorize the release of the following protected health information.

(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☑ Other: ANY and ALL records from DOI:

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐Vocational Rehabilitation ☐ HIV (AIDS)
☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes
☐ Other_____

This authorization shall expire on one year from date of initial visit **(date or event) and is needed for the period beginning** _____ **and ending** _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Agency Representative	**Title**	**Date**
Telephone	**Fax**	**Email**

Louisiana Department of Health and Hospitals

Authorization to Release or Obtain Health Information (including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: Medical Rehab Accident Injury Center

Mailing Address: 1100 N. Causeway Blvd.

City, State, Zip Code: Metairie, LA 70001

Relationship: Healthcare Provider Telephone Number: 504-832-1032

☑ **RELEASE Information TO** **or** ☐ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

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☐ Creating health information for disclosure to a third party.

☐ Other: (Specify)_____

I authorize the release of the following protected health information.
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☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐Vocational Rehabilitation ☐ HIV (AIDS)
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_____ _____
Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Agency Representative	**Title**	**Date**
Telephone	**Fax**	**Email**