

KING CHIROPRACTIC CLINIC
4515 SW Corbett Ave
Portland, OR 97229
503-224-5464

Patient Name: _____

Date of Injury: _____

Claim #: _____

Insurance: _____

Claim Manager Name: _____

Claim Manager Number: _____

Estimated damage to vehicle: \$ _____

**Please email vehicle damage photographs to
cbarmore@qwestoffice.net, so we can have them on file.**

PERSONAL INJURY INTAKE FORM

PATIENT INFORMATION

Today's Date: _____

Last Name:	MI:	First Name:
Home Address:	City:	State: Zip:
Date Birth: _____	Age: _____	Occupation: _____
Height: _____	Weight: _____	Marital Status (Circle): Single, Married, Divorced, Widowed

<input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the following telephone numbers: <input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the use of my name/address Home: _____ Work: _____ Cell: _____ Pager: _____ Indicate if you have a preferred mailing address: _____ _____ Signature: _____ Date: _____ Expiration Date/Event for Authorization: <input type="checkbox"/> No expiration date <input type="checkbox"/> When I have discontinued treatment and all bills have been paid. <input type="checkbox"/> Date: _____	Dr. Kings office, located at 4515 SW Corbett Ave, Portland OR 97239, needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.
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AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have medical payment insurance for the vehicle you were in?	<input type="checkbox"/> I have, <input type="checkbox"/> Someone else has coverage. Indicate the name of the person that the policy is under:
How is this person related to you?	<input type="checkbox"/> Self, <input type="checkbox"/> Parent, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: _____ Telephone (area code): _____
Claim Number:	
Do you have an Insurance Deductible?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Deductible is: \$ _____
Do you know your Policy Limits for medical bills?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Limit is: \$ _____
Have you reported this injury to your insurance carrier?	<input type="checkbox"/> Yes, <input type="checkbox"/> No

<input type="checkbox"/> Yes, <input type="checkbox"/> No. Do you have an attorney representing you? If yes, indicate name, address and telephone of your retained attorney:	Attorney Name: _____ Address: _____ Telephone: _____
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You are ultimately responsible for any charges incurred in this office and will be **"balance Billed"** for any amount the insurance carrier(s) does not pay. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.

Patient Signature _____ Date: _____	I acknowledge that I am ultimately responsible for all charges that are incurred at the doctor's office. I agree to pay for any outstanding bills incurred in this office, as well as paying for co-insurance or deductibles.
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Doctor's Name/Address: Valerie A. King D.C. 4515 SW Corbett Ave, Portland OR 97239

GENERAL HEALTH HISTORY (Page 2)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	History of poor healing or told that you have a healing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any disease such as AIDS, Tuberculosis, Meningitis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or any other neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, paralysis, or any disease affecting nerves/brain?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment of any type?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused/abnormal vertebrae?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why/When:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure? If yes, name of MD seeing:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have any type of chest or breast implants presently (males & females)?	N/A	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY AND/OR PREVIOUS PAIN (I have never had any injuries or pain) If yes, check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> arm numb/tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg Pain/Tingling	<input type="checkbox"/> Other Pain:	

Describe:

FRACTURES/BROKEN BONES HISTORY

(I have never had any broken bones). If you have broken/fractured any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib(s) or sternum chest bone	
<input type="checkbox"/> Arm or hand bones		<input type="checkbox"/> Leg or foot bones	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other: List	

PREVIOUS SURGERIES

(I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Abdominal/chest Surgery or Appendix	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Liver/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain/Spinal Cord/Nerve		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Doctor's Name: Valerie A. King D.C. 4515 SW Corbett Ave, Portland OR 97239	Patient Name:
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GENERAL HEALTH HISTORY (Page 3)

No, Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe: _____

No, Yes **Have you ever been to a Chiropractor before for any condition?**

If yes, Chiropractor's Name/City : _____ Year: _____

List Problem(s) that the Chiropractor treated you for: _____

No, Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

I am not taking any medications currently. If yes, list all medications that you are taking currently.

WHEN IS YOUR PAIN WORSE (Example: morning, evening, during sleep) _____

WHAT PHYSICAL ACTIVITIES INCREASE YOUR PAIN? _____

WHAT PHYSICAL ACTIVITIES LESSEN YOUR PAIN? _____

DO YOU EXERCISE?

- | | | |
|--|---|---|
| <input type="checkbox"/> I do no regular exercise | <input type="checkbox"/> I exercise 1-2 times a week | <input type="checkbox"/> I exercise 3-5 times a week |
| <input type="checkbox"/> I stretch regularly | <input type="checkbox"/> I do weight lifting at gym/home | <input type="checkbox"/> I do cardiovascular work outs |
| <input type="checkbox"/> I am willing to do exercise | <input type="checkbox"/> I am not willing to do exercises | <input type="checkbox"/> I do regular sports activities |

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

- | | | |
|--|--|--|
| <input type="checkbox"/> Excessive fatigue-malaise | <input type="checkbox"/> Bowel or bladder disorders | <input type="checkbox"/> Night pain or night time sweats |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Ovarian pain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Kidney pain/painful urination | <input type="checkbox"/> Balance problems |

Since the injury did your pain and other symptoms come on? Suddenly, Gradually

Doctor's Name: Valerie A. King D.C.

Patient Name:

NECK, MIDDLE BACK, AND EXTREMITY QUESTIONNAIRE (Page 4)

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can ask questions or clarify your answers at that time.

YES NO

NECK REGION

<input type="checkbox"/>	<input type="checkbox"/>	Does neck and head movement cause your neck pain to intensify?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____ min/hrs)
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sending pain downwards to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a disc bulge or disc herniation in your neck previously?
<input type="checkbox"/>	<input type="checkbox"/>	Does your neck make a "clunk" sound when you move it?

YES NO

SHOULDER, ARM, HAND, OR FINGER REGION

<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in your shoulder(s)? If yes, describe where:
<input type="checkbox"/>	<input type="checkbox"/>	Does arm motion make your shoulder pain worse? Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your upper arm, elbow, forearm, or hand? Circle areas
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
<input type="checkbox"/>	<input type="checkbox"/>	Do you get increased arm numbness when lying flat on your back or sleeping on your side?
<input type="checkbox"/>	<input type="checkbox"/>	Does changing your sitting posture increase your arm/hand symptom intensity?
<input type="checkbox"/>	<input type="checkbox"/>	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm/hand symptoms, do they improve when you lift your arms over your head?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm/hand symptoms, do they worsen when you lift your arms over your head?
<input type="checkbox"/>	<input type="checkbox"/>	If you have hand or arm pain at night, does it help to shake and massage them?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands feel tender when you grasp objects?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel weakness in your grip strength or do you drop objects from your hand?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty writing or doing small motions with your fingers recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hand(s) or wrist swell?
<input type="checkbox"/>	<input type="checkbox"/>	Recently, have your fingers or hands been cold or burning? Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?

YES NO

MIDDLE BACK AND CHEST WALL REGION

<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
<input type="checkbox"/>	<input type="checkbox"/>	When you move your neck around, does your middle back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having angina before?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like feeling sometimes around your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back pain mostly bother you during sleep?

Doctor's Name: Valerie A. King D.C.	Patient Name:
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Form 1030

LOW BACK, HIP, LEG AND FOOT QUESTIONNAIRE (Page 5)

Check any of the following that intensify your low back pain and/or leg symptoms:

<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Standing up	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing still	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Lying on your back	<input type="checkbox"/> Putting on shoes

Check any of the following that lessen/improve your low back pain and/or leg symptoms:

<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending forwards	<input type="checkbox"/> Standing up	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing still	<input type="checkbox"/> Bending backwards	<input type="checkbox"/> Lying on your back	<input type="checkbox"/> Putting on shoes

Check all locations of any current leg pain, numbness, or tingling:

<input type="checkbox"/> Hip	<input type="checkbox"/> Buttock	<input type="checkbox"/> Back of thigh	<input type="checkbox"/> Calf
<input type="checkbox"/> Groin area	<input type="checkbox"/> Knee	<input type="checkbox"/> Front of thigh	<input type="checkbox"/> Foot/toes

YES NO *Check all areas with a yes or no (Skip if you are unclear about question)*

<input type="checkbox"/>	<input type="checkbox"/>	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
<input type="checkbox"/>	<input type="checkbox"/>	Does either leg or foot drag on the floor when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a lot of leg cramps at night recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
<input type="checkbox"/>	<input type="checkbox"/>	Have you observed that your low back pain is not relieved or made worse by any type of postural change?
<input type="checkbox"/>	<input type="checkbox"/>	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injection of Chymopapain into your discs (Spine) in your back or neck?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Does one or both of your legs feel weak recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
<input type="checkbox"/>	<input type="checkbox"/>	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
<input type="checkbox"/>	<input type="checkbox"/>	If you have radiating leg or foot pain did you notice your leg symptoms before the low back pain started?
<input type="checkbox"/>	<input type="checkbox"/>	If you have leg pain, is your pain primarily focused in front of your thigh(s)?
<input type="checkbox"/>	<input type="checkbox"/>	Has your anal-rectal region been completely numb?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any recent prostate, ovarian, or uterine problems?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had abdominal surgery, chest surgery, reconstructive surgery or other conditions in your past where your doctor has recommended that you should be careful when twisting or lifting?
<input type="checkbox"/>	<input type="checkbox"/>	Other:

YES NO SLEEPING PATTERNS

<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep poorly at night?
<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep on your stomach?
<input type="checkbox"/>	<input type="checkbox"/>	Do you consistently feel extremely tired when you wake up in the morning?

Doctor's Name: Valerie A. King D.C.	Patient Name:
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Form 1040

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE (Page 6)

Patient Name: _____ Date: _____

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS PRESENTLY	HAD SIMILAR SYMPTOMS WITHIN 12-MONTHS PRIOR TO THE INJURY
Headache/migraine				
Nausea/vomiting				
Dazed, stunned, or dizziness				
Tinnitus (ear ringing)				
Visual problems				
Memory or concentration problems				
Forgetful of recent events/activities				
Feeling mentally "foggy"				
Balance or coordination problems				
Sleeping difficulties				
Sensitivity to sound or light				
Fatigue, drowsy, feeling slowed down				
Loss of smell or taste				
Pain/difficulty chewing				
Jaw pain/soreness/clicking				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Hand coordination problems				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other				

Doctor's Name: Valerie A. King D.C	Patient Name:
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MOTOR VEHICLE CRASH FORM (Page 7)

Patient Name: _____ Date: _____
 Date of crash: _____ Time of collision: _____ AM PM
 City where crash occurred: _____ Was the street wet or dry? Wet Dry
 Street (location) where crash occurred: _____
 Who owns the vehicle in which you were hit? _____
 What is the estimated repair damage to your vehicle? \$ _____ Unknown, Estimate not done yet
 How many people were in your vehicle at the time of the crash? _____
 Yes, No Did the police come to the crash scene?
 Yes, No Did the police make a written report?
 Yes, No Were any photographs taken of the vehicles? If yes, who took them?

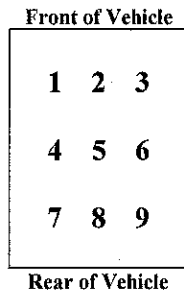
DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

<input type="checkbox"/> Single-vehicle crash	<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Three-or-more vehicles
<input type="checkbox"/> Rear-end crash	<input type="checkbox"/> Side crash	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on or frontal crash	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (Describe): _____		

CIRCLE YOUR SEATING POSITION (The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.)



DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: _____ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: _____ Unknown

Doctor's Name/Address: Valerie A. King D.C. 4515 SW Corbett Ave, Portland OR 97239

Form 4010

MOTOR VEHICLE CRASH FORM (Page 8)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other:

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object/curb other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE COLLISION:

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat bent or damaged	<input type="checkbox"/> Dash or area around knee/foot
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side or rear window broken	<input type="checkbox"/> Other

Describe Damage:

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did you strike or did any objects or animals within your vehicle hit you during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to a point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the crash? If yes, circle (side airbag/front airbag)
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any cuts, bruises, or abrasions from the airbag deploying?
<input type="checkbox"/>	<input type="checkbox"/>	Did your seatbelt system require repairs after the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Was the back of your seat that your were sitting in damaged or bent during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

Doctor's Name: Valerie A. King D.C.	Patient's Name:
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Form 4010

MOTOR VEHICLE CRASH FORM (Page 9)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have a: <input type="checkbox"/> Lap and Shoulder Strap, <input type="checkbox"/> Automatic shoulder strap with driver needing to manually attach lap belt, <input type="checkbox"/> Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any cuts, bruises, or abrasions from the seatbelts?
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned (<i>Use time clock face as your reference point</i>) Left hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

- | | |
|--|--|
| <input type="checkbox"/> Movable/adjustable head restraint | <input type="checkbox"/> Fixed, non-moveable head restraint |
| <input type="checkbox"/> No headrests in my vehicle | <input type="checkbox"/> Bench seat in your vehicle without head restraint |

Please indicate how your head restraint was positioned at the time of crash (if present):

- | | |
|--|---|
| <input type="checkbox"/> At the top of the back of your head | <input type="checkbox"/> Midway height of the back of your head |
| <input type="checkbox"/> Lower height of the back of your head | <input type="checkbox"/> Located at the level of your neck |
| <input type="checkbox"/> Level of your shoulder blades | |

BRUISING AFTER THE CRASH?

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising (if known):
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AWARENESS AND BODY POSITION DESCRIPTIONS: Check all areas that apply to you.

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending crash and relaxed before the collision.
<input type="checkbox"/>	You were aware of the impending crash and braced yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left, <input type="checkbox"/> Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
<input type="checkbox"/>	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
<input type="checkbox"/>	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU *FIRST* NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

Doctor's Name: Valerie A. King D.C.	Patient's Name:
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Form 4010

PROVIDERS SEEN SINCE THE COLLISION (Page 11)

Start with the first hospital/clinic/doctor/therapist that you went to after your motor vehicle crash and list all health care providers (all types of doctors or therapists), up to your last health care provider seen, and check all that apply for each. Be certain to list these in sequence from first health care provider seen to the last.

① Name Emergency Room, hospital/doctor/therapist/center: _____
 Address: _____ Date _____

Indicate what was done:

- | | | |
|--|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> Exam or consult only (no treatment) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck or head | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/ribs/middle back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back/pelvis/hips | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> X-ray of shoulder/arms/legs | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other: _____ |

Indicate if treatment with this provider: Helped, Did not help, Made condition worse

② Name hospital/doctor/therapist/center seen: _____
 Address: _____ Date _____

Indicate what was done:

- | | | |
|--|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> Exam or consult only (no treatment) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck or head | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/ribs/middle back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back/pelvis/hips | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> X-ray of shoulder/arm/leg | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests: _____ | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other: _____ |

Indicate if treatment with this provider: Helped, Did not help, Made condition worse

③ Name of hospital/doctor/therapist/center: _____
 Address: _____ Date _____

Indicate what was done:

- | | | |
|--|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> Exam or consult only (no treatment) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck or head | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/ribs/middle back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back/pelvis/hips | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> X-ray of shoulder/arm/leg | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests: _____ | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other: _____ |

Indicate if treatment with this provider: Helped, Did not help, Made condition worse

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

KING CHIROPRACTIC CLINIC

4515 SW Corbett Ave Portland OR 97239

IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay the debt owed and 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 grant, sell, bargain, 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 verdicts 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: _____ Attorney Name: _____

Patient Signature: _____

Date: _____