Dr. David Van, DC
WoodlandHillsChiropractor.com
6355 Topanga Cyn Blvd #504
Woodland Hills, CA 91367
Office: (818) 884-2576
Fax: (818) 884-8054

Please fill out the form in as much detail as possible:

Name____ Date ______________________________

Address_________________________Apt.# ____ City_____________________ State_____ Zip __________

Phone: Home _______________________ Mobile _______________________Work ___________________

Age_______DOB_________________ Sex: M / F Occupation _____________________________________

Social Security # ____Marital Status: M / S / D / W

Height__________ Weight___________ E-mail Address ____

Emergency Contact __________________________ Relationship ______________ Phone ________________

Primary Problem ____

Date of injury/onset ____

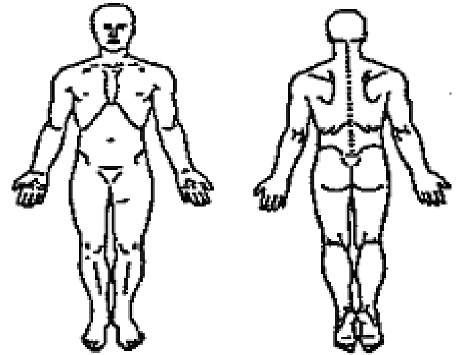
How did it happen? ____

What makes it worse?____

What makes it better?____

Rate your problem: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Is the problem getting worst? No / Yes, Explain ______________________



Describe how the pain feels? (Sharp, Dull, Achy, Shock-Like, Burning, Etc.) ____________________________

Does the problem radiate into the arms/legs? ☐No ☐Yes, Where ____________________________________

At what time of day is the problem worst? ☐Constant ☐Morning ☐Afternoon ☐Evening ☐Night

Have you ever had a similar problem before? ☐No ☐Yes, When? ____________________________________

Are you taking any medication for this problem? ☐No ☐Yes, List ____________________________________

Please check all of the following that apply to you:

No	Yes		No	Yes		No	Yes	
☐	☐	Recent Infection	☐	☐	Headaches	☐	☐	Cancer/Tumor ______________
☐	☐	Recent Fever	☐	☐	Jaw Pain: L / R	☐	☐	Recent Frequent Urination
☐	☐	HIV / AIDS	☐	☐	Neck Pain	☐	☐	Recent Urinary Retention
☐	☐	Diabetes	☐	☐	Upper Back Pain	☐	☐	Birth Control Pills
☐	☐	High Blood Pressure	☐	☐	Lower Back Pain	☐	☐	Pregnancy, # of births ________
☐	☐	Epilepsy / Seizers	☐	☐	Shoulder Pain: L / R	☐	☐	Numbness in the Groin/Buttocks
☐	☐	Dizziness / Fainting	☐	☐	Elbow Pain: L / R	☐	☐	Prostate Problems
☐	☐	Visual Disturbance	☐	☐	Wrist/Hand Pain: L / R	☐	☐	Stroke (Date) _____________
☐	☐	Osteoporosis	☐	☐	Hip Pain: L / R	☐	☐	Alcohol Use ________________
☐	☐	Corticosteroid Use	☐	☐	Knee Pain: L / R	☐	☐	Tobacco Use ________________
☐	☐	Arthritis	☐	☐	Ankle Pain: L / R	☐	☐	Surgeries __________________
☐	☐	Aortic Aneurysm	☐	☐	Foot Pain: L / R	☐	☐	Medications_________________

Family History: ☐Arthritis ☐High Blood Pressure ☐Cancer ☐Diabetes ☐Heart Problems

I certify that the above information is true and accurate. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due and payable.

Patient's Signature ______________________________________ Date ______________________________

ASSIGNMENT AND LIEN AUTHORIZATION

FOR: ______________________________
Patient's Name

TO: ______________________________
Attorney at Law
____
____

David D. Van, DC (Provider)

6355 Topanga Canyon Blvd., #504
Woodland Hills, CA 91367
Phone: (818) 884-2576
Fax: (818) 884-8054

I do hereby authorize the **Provider named above** and or authorized representatives to furnish you, my attorney or any attorney or attorneys who subsequently are either Associates with said named attorney, or substituted in his/her place, with a full report of their examination, diagnosis, treatment, prognosis, and itemized statement of charges in regard to the accident which I was involved. Furthermore, I hold the Provider, free and harmless from any liability in such transfer of information.

I hereby authorize direct payment to the Provider such sums due and owing to them for medical service rendered me both by reason of this accident or by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said Provider. I further give a lien to said Provider on any and all funds received by me or on my behalf in connection with any settlements, judgments or verdicts regarding this case. I agree never in 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 shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

In the event legal action shall be taken in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment or settlement rendered. I fully understand that I am directly and fully responsible to Provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said Provider's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

A PHOTOGRAPHIC REPRODUCTION OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL

Patient's Signature: ______________________________ Date: ______________________________

The undersigned being the attorney of record on his/her own behalf and on behalf of any other attorney or attorneys who are Associates with the undersigned or who are substituted in his/her stead for the above patient, does hereby acknowledge that he/she is obligated to all terms stated above, and agrees to withhold such sums from any settlements, judgments, or verdicts as is necessary to adequately protect said Provider.

Attorney's Signature: ______________________________ Date: ______________________________

MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name:____ Date: _______________

Date of injury:_________________________ Time of injury _____________________ ☐ AM ☐ PM

City where crash occurred: ______________________________ was the street wet or dry? ☐ Wet ☐ Dry

Street (location) where crash occurred: ____

What is the estimated damage to your vehicle? $____

Who made damage estimates on your vehicle? ____

Who owns the vehicle you were involved in: ____

☐ Yes, ☐ No Did the police come to the accident scene?

☐ Yes, ☐ No Did the police makes a written report?

☐ Yes, ☐ No Were any photographs taken of your vehicle? If yes, who took them?

DESCRIBE HOW THE CRASH HAPPENED

____

____

____

____

COLLISION DESCRIPTION-TYPE

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

☐	Single-car crash	☐	Two-vehicle crash	☐	Three or more vehicles
☐	Rear-end crash	☐	Side crash	☐	Rollover
☐	Head-on crash	☐	Hit guard rail, tree, or object	☐	Ran off the road
☐	Other (Describe):				

INDICATE YOUR SEATING POSITION

☐	Driver	☐	Front passenger	☐	Left rear passenger	☐	Right rear passenger

DESCRIBE THE VEHICLE YOU WERE IN:

Model, Make, and Year:

☐	Small-sized car	☐	Mid-sized car	☐	Large-sized car
☐	Pick-up truck	☐	Van	☐	Sport Utility Vehicle
☐	2 Door vehicle	☐	4 Door vehicle	☐	Large truck, bus, or semi-truck
☐	Sedan	☐	Hatchback	☐	Station wagon
☐	Other (Describe):				

DESCRIBE THE OTHER VEHICLE (If not certain, leave blank):

Model, Make, and Year: ☐ Unknown

☐	Small passenger car	☐	Mid-sized passenger car	☐	Van
☐	Pick-up truck/sports utility	☐	Large-sized passenger car	☐	Large truck, bus, or semi-truck

MOTOR VEHICLE CRASH FORM (Page 2)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐	Slowing down	☐	Gaining speed
☐	Stopped	☐	Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐	Slowing down	☐	Gaining Speed	☐	Unknown speed
☐	Stopped	☐	Moving at steady speed	☐	Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object 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
Face	Side window
Shoulder	Side door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt
Hip/abdomen	Frame of car near windows
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

☐	Windshield	☐	Seat frame	☐	Knee bolster
☐	Steering wheel	☐	Side-rear window	☐	Other
☐	Dash	☐	Mirror	☐	Other

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES	NO	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes, circle (side air bag/front air bag)
☐	☐	Were you intoxicated (alcohol) at the time of crash?

MOTOR VEHICLE CRASH FORM (Page 3)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES	NO	
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap and Shoulder Strap, ☐ Lap belt only
☐	☐	Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned (Use time clock face as your reference point) Left hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere Right hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere

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

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint
☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

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

☐ At the top of the back of your head ☐ Midway height of the back of your head
☐ Lower height of the back of your head ☐ Located at the level of your neck
☐ Level of your shoulder blades

BRUISING AFTER THE CRASH

YES	NO	
☐	☐	Did your body have any bruising (areas that were visibly black and blue) after the crash? If yes indicate where:________________________________

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all areas that apply to you.

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

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate name of person policy is under:
How is this person related to you	☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Automobile Insurance Carrier:	
Phone Number Of Automobile Insurance Carrier:	
Claim Adjuster's Name:	
Claim Adjuster's Telephone Number:	
Claim Number:	
Do you have an Insurance Deductible?	☐No ☐Yes, Deductible is: $
Do you know your Policy Limits for medical bills?	☐No ☐Yes, Limit is: $
Have you reported this injury to your insurance carrier?	☐No ☐Yes

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.* ***Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.***

It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Do you have an attorney representing you? ☐No ☐Yes If yes, indicate name and address:	Attorney Name: ______________________________ Address: ______________________________ Telephone: ______________________________

Signature____ **Date** ________________

Print Name ____