Dr. Eddy Mydouangchanh, D.C.

MDC Chiropractic
14455 SW Allen Blvd. Suite 102
Beaverton, OR 97005
(971) 303 - 8880

Alameda Family Chiropractic
4410 NE Fremont Street
Portland, OR 97213
(503) 249 - 0114

P A T I E N T I N F O R M A T I O N

Patient's Name_______________________________ Today's Date______________
(Last) (First) (Middle) (Nickname)

Address_______________________________ Zip Code______________
(Street) (City) (State)

Email Address_______________________________

Home Phone (____)______________ Work Phone (____)______________ Cell Phone(____)______________

Receive appointment reminders by text? ☐ Yes ☐ No • Cell Phone Provider: ______________

☐ Male ☐ Female Age______________ Birthdate______________________
(Month/ Date/ Year)

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Separated ☐ Partnered for _____ years

Patient's Employer/School ______________________ Occupation______________

Employer/School Address_______________________________

Spouse/Parent's Name______________________ Birthdate______________

Spouse/Parent's Employer______________________ Phone (____)______________

☺ Whom may we thank for referring you?_______________________________☺

M E D I C A L

Date of last general exam______________ Primary Care Physician______________________

List any allergies you have (Drug, food, Hay Fever, Other)_______________________________

List any Medications you are taking_______________________________

Do you have: **High Blood Pressure**? ☐ Yes ☐ No **Diabetes**? ☐ Yes ☐ No **High Cholesterol**? ☐ Yes ☐ No

Describe any conditions we should know about_______________________________

Are you seeing the doctor because of an accident? ☐ Auto ☐ Work ☐ Home ☐ None

---

I N S U R A N C

Who is responsible for this account?_______________________________

Primary Insurance Co.______________________ Policy Holder______________

ID/Claim #:___________________________Group/Policy #: _______________________Phone (______)___________________

➔ **Please provide your Insurance Card so we may take a copy of it!!**

Secondary Insurance Co.____ Policy Holder_____________________________

ID/Claim #:___________________________Group/Policy #: _______________________Phone (______)___________________

Insurance Assignment and Release

I certify that I have Insurance coverage with ____

Name of Insurance Company(s)

And assign directly to Dr. Eddy B. Mydouangchanh, D.C. all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____

____

Signature of patient or Parent if minor   Please print name of patient or parent if minor

____

____

Date of signature   Relationship to Patient

By signing this form I also understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits.

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SYMPTOMS & INJURIES QUESTIONNAIRE

Patient Name:____ Date:__________________

Mark all that apply

Concussion?	❑ Yes	❑ No
Headaches?	❑ Yes	❑ No
Dizziness?	❑ Yes	❑ No
Nausea?	❑ Yes	❑ No
Loss of Balance?	❑ Yes	❑ No
Ringing in Ears?	❑ Yes	❑ No
Blurred Vision?	❑ Yes	❑ No
Loss of Memory?	❑ Yes	❑ No
Fluid in Ears?	❑ Yes	❑ No
Vomiting?	❑ Yes	❑ No
Jaw Pain?	❑ Yes	❑ No
Eating Difficulty?	❑ Yes	❑ No
Chewing Difficulty?	❑ Yes	❑ No
Neck Pain?	❑ Yes	❑ No
Shoulder Pain?	❑ Yes	❑ No
Back Pain?	❑ Yes	❑ No
Hip Pain?	❑ Yes	❑ No

☆ Please **CIRCLE** the areas of complaint. Indicate with the appropriate symbol the nature of your symptom*(s)*

Dull/ Achy Pain ~ ZZZ
Numbness ~ XXX
Burning Pain ~ BBB
Shooting Pain ~ ϟ ϟ
Swelling ~ SSS
Tingling ~ ===
Throbbing ~ vvv

Numbness or Tingling in the arms/hands/fingers?	❑ Yes	❑ No	❑ Right	❑ Left
Numbness or Tingling in the legs and/or feet?	❑ Yes	❑ No	❑ Right	❑ Left

IMPAIRED ACTIVITIES (Circle those that apply)

Sports	Aerobic Exercise	Archery	Backpacking	Bowling
Badminton	Baseball	Basketball	Basketry	Bicycling
Boxing	Card Playing	Camping	Dancing	Fencing
Fishing	Flying	Football	Gardening	Golf
Handball	Gymnastics	Health Clubs	Hockey	Hunting
Judo	Horseback Riding	Ice Skating	Karate	Painting
Pottery	Jogging/Running	Photography	Racquetball	Rafting
Yoga	Mountain Climbing	Snow Skiing	Sailing	Tennis
Soccer	Rowing/Boating	Softball	Water Skiing	Swimming
Walking	Musical Instruments	Volleyball	Weight Lifting	

DAY TO DAY ACTIVITIES (Circle those that apply)

Dressing	Bathing/Showering	Bending	Brushing Teeth	Cooking
Holidays	Dining Out	Ironing	House Cleaning	Movie Going
Laundry	Sexual Relations	Lifting	Church Events	Crafting
Moving	Shampooing Hair	Reading	Shaving	Shopping
Sitting	Watching TV	Sleeping	Social Events	Standing
Traveling	Car Washing	Vacations	Yard Work	Child Care

WORK-RELATED ACTIVITIES (Circle those that apply)

Sitting	Standing	Telephoning	Computer Work	Lifting
Reading	Bending	Typing	Writing	

Continued On Reverse Side →→→→→→

HEALTH HISTORY (Mark those that apply)

Past	Current		Past	Current		Past	Current	
❑	❑	Allergies	❑	❑	Goiter	❑	❑	Pleurisy
❑	❑	Appendicitis	❑	❑	Heart Attack	❑	❑	Pneumonia
❑	❑	Arthritis	❑	❑	Hepatitis (HAV, HBV, HCV)	❑	❑	Polio
❑	❑	Asthma	❑	❑	Herpes	❑	❑	Rheumatic Fever
❑	❑	Cancer	❑	❑	Scarlet Fever	❑	❑	Smallpox
❑	❑	Chickenpox	❑	❑	Influenza	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Kidney Disease	❑	❑	Tuberculosis
❑	❑	Diphtheria	❑	❑	Lumbago	❑	❑	Urinary Tract Infection
❑	❑	Eczema	❑	❑	Malaria	❑	❑	Thyroid Disease
❑	❑	Emphysema	❑	❑	Measles	❑	❑	Whooping Cough
❑	❑	Epilepsy	❑	❑	Mumps	❑	❑	Typhoid Fever

List all surgeries you have had (Chronologically)

_________________________Month/Year________________Physician____________________________City_______________

_________________________Month/Year________________Physician____________________________City_______________

_________________________Month/Year________________Physician____________________________City_______________

_________________________Month/Year________________Physician____________________________City_______________

Remarks:____

List ALL serious accidents & injuries that you have had

____Month/Year________________Hospitalized? ❑ Yes ❑ No

____Month/Year________________Hospitalized? ❑ Yes ❑ No

____Month/Year________________Hospitalized? ❑ Yes ❑ No

____Month/Year________________Hospitalized? ❑ Yes ❑ No

Remarks:____

List any fractures, dislocations, or concussions that you have had

____Month/Year________________Hospitalized? ❑ Yes ❑ No

____Month/Year________________Hospitalized? ❑ Yes ❑ No

____Month/Year________________Hospitalized? ❑ Yes ❑ No

____Month/Year________________Hospitalized? ❑ Yes ❑ No

Remarks:____

List ALL medications and/or supplements that you are currently taking

________________________________Frequency_______Prescribed By:__________________________Month/Year________

________________________________Frequency_______Prescribed By:__________________________Month/Year________

________________________________Frequency_______Prescribed By:__________________________Month/Year________

________________________________Frequency_______Prescribed By:__________________________Month/Year________

Remarks:____

PREVIOUS CHIROPRACTIC CARE ❑ None ❑ Occasional ❑ Frequent

Name of Chiropractor__________________________________Dates_____/_____ to _____/_____City____________________

Name of Chiropractor__________________________________Dates_____/_____ to _____/_____City____________________

Remarks:____

X-RAY EXPOSURE (*EXCLUDING Dental or Chest X-Rays)*

❑ None ❑ Few ❑ Several ❑ Many

FAMILY HISTORY Please list any pertinent family health conditions (grandparents, parents, siblings) Dr. Eddy Should know about:

____

____

____

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HIPAA OMNIBUS NOTICE of PRIVACY PRACTICES

(Revised 2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc.., to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a specific procedure, therapy, DME, or nutritional supplies, etc…, may require that your relevant protected health information be disclosed to the health plan to obtain approval for payment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as needed, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES ABD DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to abject unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.
You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and request a copy of your protected health information *(fees may apply)* – Pursuant to your written request, you have the tight to inspect or request a copy of your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or obtain a copy of the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.
You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare which you have paid in full out of pocket.
You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively *(i.e. electronically)*.
You have the right to request an amendment to your protected health information – If we deny your request for amendment; you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: Pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six (6) years prior to the date of request.
You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice of you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your physician or office manager of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please contact our office and we will be happy to assist you.

Also, please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

______________________________	______________________________
Signature of patient *(or Parent if minor)*	Please print name of patient *(or parent if minor)*
______________________________	______________________________
Date of signature	Relationship to Patient

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Patient Confidentially Questionnaire

Please list any family members or other persons whom we may contact in case of an emergency or discuss your general condition & diagnosis *(including treatment, payment, appointments & health care operations)*:

Name: ______________________________ Phone Number: ____________________

Name: ______________________________ Phone Number: ____________________

Name: ______________________________ Phone Number: ____________________

Name: ______________________________ Phone Number: ____________________

Please print the telephone number you prefer to receive calls about appointments or any other health care information:
***PLEASE NOTE**: I am fully aware that a cell phone is not a secure and private line.*

____

Can confidential messages *(such as appointment reminders)* be left on your telephone answering machine or voicemail?

❑ YES ❑ NO

Please print the address where you would like your billing statements and/or correspondence from our office to be sent:

Address:____

City:______________________________ State:__________ Zip:______________

Please indicate if you would like all correspondence from our office sent to you in a sealed envelope marked **"CONFIDENTIAL"**

❑ YES ❑ NO

____
Signature of Patient *(or Parent if minor)*

____
Please Print Name of Patient *(or parent if minor)*

____
Date of Signature

____
Relationship to Patient

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Informed Consent To Chiropractic Treatment

Patient Name: ____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of chiropractic treatment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. The doctor may use his hands or a mechanical instrument upon your body in such a way to move your joints. The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel a sense of movement in the joint.

Analysis / Examination / Treatment:

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

_____ Spinal Manipulative Therapy
_____ Range of Motion Testing
_____ Muscle Strength Testing
_____ Hot/Cold Therapy
_____ Cupping
_____KT Taping/Strapping
_____ Palpation
_____ Orthopedic Testing
_____ Postural Analysis Testing
_____ Electrical Muscle Stimulation
_____ Mechanical Traction
_____ Other: ____
_____ Vital Signs
_____ Basic Neurological Testing
_____ Ultrasound Therapy
_____ Soft-Tissue Massage Therapy
_____ Hydro-Massage Therapy

*****Patient should initial each procedure they are consenting to*****

Possible Risks:

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. Complications from chiropractic treatments could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

****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 the doctor.**

Probability of risks occurring:

The risks of complications due to chiropractic treatments have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the doctor will check for during the taking of your history and during examination. The doctor may refer you to have X-Ray's taken if concern arises during your examination. 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 the specific incident of this complication occurring. If there is a casual 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 for arterial stroke.

The availability and nature of other treatment options:

Other treatment for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

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If you chose to use one of the above noted "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.

Continued on Reverse Side
➔➔➔➔➔➔➔

Risks of remaining untreated:

Remaining untreated or the delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult and/or less effective.

Informed Consent To Chiropractic Treatment (MINOR)

I hereby request and authorize Dr. Eddy Mydouangchanh, DC to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor son/daughter: ____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination and/or referral 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 or other parent is not required. If my authority to so 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.

Please check the appropriate box and sign below:

❒ **I have read the above explanation of the chiropractic adjustment and related treatments MYSELF.**

❒ **The above explanation of chiropractic adjustment and related treatments was READ TO ME.**

I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. Having been informed of the risks, I have freely decided to undergo the recommended treatment and herby give my full consent to treatment with Dr. Eddy Mydouangchanh. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the recommended treatment.

______________________________	______________________________
Signature of patient or Parent if minor	Please print name of patient or parent if minor
______________________________	______________________________
Date of signature	Relationship to Patient

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Dr. Eddy's Office Policies

☺ Thank you for choosing Dr. Eddy for your healthcare needs ☺

Payment and Insurance:
Payment is expected at the time of service unless other arrangements have been made prior to your appointment. This applies to insurance copays and deductibles.

Private Health Insurance:
As a courtesy to you, we are happy to submit bills to your health insurance company on your behalf. We will make every effort to obtain reimbursement from your insurance company. However, YOU are ultimately responsible for the cost of treatment that is not covered or denied by your insurance.

Motor Vehicle Collisions and Workers Compensation
If you have been injured in a motor vehicle collision or on the job, we will bill YOUR auto or workers compensation insurance. If you are represented by an attorney, s/he will be provided with duplicate copies of all documents sent to your insurance.

It is important to understand that while PIP or Work Comp insurance generally covers all expenses for your treatment, you are ultimately responsible for any unpaid balance from a denied expense/charge.

It is not uncommon for Auto or Work Comp insurance payments to be delayed, often up to 60 days or longer after receipt of billing from our office. With that said; any unpaid balance that extends beyond 60 days may be subject to a monthly finance charge of 1.5% interest.

Appointments, Cancellations & Returned Checks:
In order to accommodate the needs of other patients, we require a 24 hour notice of cancellation. Please be respectful of this policy. While some circumstances are certainly understandable and unavoidable, we reserve the right to charge $35.00 for missed appointments, as well as, checks that are returned because of insufficient funds. Any charges that our bank applies to such a transaction will also be your responsibility.

I have read and understand the above office policies:

_______________________________ Signature of patient or Parent if minor

_______________________________ Please print name of patient or parent if minor

_______________________________ Date of signature

_______________________________ Relationship to Patient

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IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT OF RECOVERY

In consideration and exchange for not having to immediately pay a debt owed; and in consideration for receiving future care by Dr. Eddy Mydouangchanh upon whose letterhead this document is printed, I, the undersigned, hereby assign and convey to Dr. Mydouangchanh 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 and treatment provided or to be provided to me by Dr. Mydouangchanh.

I hereby authorize and direct my attorney(s) to hold in trust and to pay directly to Dr. Eddy Mydouangchanh such sums as may be due and owing her for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due to Dr. Mydouangchanh; and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect Dr. Mydouangchanh. I hereby further give, grant and convey a lien on my case to Dr. Mydouangchanh against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which 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 Dr. Mydouangchanh.

I fully understand that I am directly and fully responsible to Dr. Eddy Mydouangchanh for all charges incurred for services rendered me and that this agreement is made solely for Dr. Mydouangchanh's additional protection and in consideration for Dr. Mydouangchanh's waiting for payment. I further understand that payment for services rendered by Dr. Mydouangchanh is not contingent on any settlement, judgment or verdict by 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 Dr. Eddy Mydouangchanh's interest, he may require me to make payments on a regular current basis. Dr. Mydouangchanh may also bring a cause of action against my attorney*(s)* for failing to honor this binding and irrevocable lien agreement between myself and Dr. Eddy Mydouangchanh.

I further understand and agree that Dr. Eddy Mydouangchanh is not responsible for paying any of my attorney's fees and he does not agree to pay my attorney*(s)* and/or attorney fees for honoring this agreement between myself and Dr. Eddy Mydouangchanh.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY*(S)* TO PROTECT DR. EDDY B. MYDOUANGCHANH'S INTEREST AT THE TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO DR. EDDY B. MYDOUANGCHANH. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM DR. EDDY B. MYDOUANGCHANH. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT OF PAYMENT AND LIEN."

______________________________	______________________________
Signature of patient or Parent if minor	Please print name of patient or parent if minor
______________________________	______________________________
Date of signature	Relationship to Patient

Dr. Eddy Mydouangchanh, D.C.

MDC Chiropractic
14455 SW Allen Blvd. Suite 102
Beaverton, OR 97005
(971) 303 - 8880 • Fax: (503) 214 - 8175

Alameda Family Chiropractic
4410 NE Fremont Street
Portland, OR 97213
(503) 249 - 0114 • Fax: (503) 249 - 5638

PERSONAL INJURY DATA

Patient Name:____ Today's Date:______________________

Date of Accident:________________________Time accident occurred:__________________ ❑ AM / ❑ PM

Driver of Vehicle:_____________________________Where were you seated:__________________________

Who owns the Vehicle:________________________Year/Make/Model of Vehicle:______________________

What is the approximate damage done to your car? $____

Year/Make/Model of the ***other vehicle***:____

Visibility at the time of the accident: ❑ Poor ❑ Fair ❑ Good ❑ Other:____________________________

Road Conditions at the time of accident: ❑ Icy ❑ Rainy ❑ Wet ❑ Clear ❑ Dark ❑ Other:__________

Type of Accident: ❑ Head-On Collision ❑ Broad-side Collision *(T-Bone)*

❑ Rear-End Collision ❑ Front-Impact *(Rear-Ended car in front of me)*

❑ Non-Collision:____

Describe what happened to you upon impact:____

____

____

Did you see the accident coming? ❑ Yes ❑ No

Did you brace for impact? ❑ Yes ❑ No

Were you wearing your seatbelt? ❑ Yes ❑ No

Did your airbag(s) deploy? ❑ Yes ❑ No

Does your car have headrests? ❑ Yes ❑ No

If yes, what was the position of the headrest compared to your head before the accident?

❑ Top of headrest was even with the BOTTOM of my head.

❑ Top of headrest was even with the TOP of my head.

❑ Top of headrest was even with the MIDDLE of my NECK.

Was your car braking? ❑ Yes ❑ No

Was your car moving at the time of the accident? ❑ Yes ❑ No

If yes, what speed would you estimate that you were traveling? _________________m.p.h.

What is the estimated speed the OTHER car was traveling at? _______________________m.p.h.

Head & Body Position at the time of impact:

❑ Head turned ❍ Left or ❍ Right

❑ Head looking back *(over shoulder)*

❑ Head straight forward

❑ Body straight in sitting position

❑ Body rotated ❍ Left or ❍ Right

❑ Other:______________________________

At the time of the accident, recall what parts of your body or head hit what parts on the inside of you car:_______

____

____

As a result of the accident you were: ❑ Rendered Unconscious ❑ Dazed/Confused ❑ Other:_____________

Were you able to move all parts of your body? ❑ Yes ❑ No

If no, what parts and why?____

Were you able to get out of you car and walk **UNAIDED**? ❑ Yes ❑ No

If no, why not?____

Did the accident result in bleeding cuts or bruises? ❑ Yes ❑ No

If yes, where were the bleeding cuts?____

If yes, where were the bruises?____

Describe how you felt **IMMEDIATELY** after the accident *(Please be specific)*:___________________________

____

Did you have pain right away? ❑ Yes ❑ No

If yes, where?____

If no, did the pain happen: ❑ Later that day *(Approximate time)*:______ ❑ Later that night *(Approximate time)*:______

❑ The next day *(Approximate Date)*:______ ❑ A few days later *(Approximate time)*:_____

Check the symptoms apparent **SINCE** the accident:

❑ Headache
❑ Neck pain/stiffness
❑ Mid-back pain
❑ Low-back pain
❑ Sensitive to light/sound
❑ Pain behind eyes
❑ Dizziness/lightheaded
❑ Fainting/blackouts
❑ Ringing/buzzing ears
❑ Loss of balance
❑ Loss of grip strength in hands
❑ Muscle soreness/pain/tenderness
❑ Clumsiness
❑ Shortness of breath
❑ Afraid to drive/ride in car
❑ Loss of smell
❑ Loss of taste
❑ Loss of memory
❑ Loss of hearing
❑ Jaw pain/clicking
❑ Visual changes/blurring
❑ Irritability
❑ Depression
❑ Sleeping problems
❑ Nausea/vomiting
❑ Sore throat
❑ Frequent urination
❑ Trouble concentrating
❑ Nightmares
❑ Easily startled
❑ Numbness in arms/fingers
❑ Numbness in legs/feet
❑ Cold hands/feet
❑ Diarrhea
❑ Constipation
❑ Chest pain
❑ Anxious
❑ Cold sweats
❑ Fatigue
❑ Heavy headed
❑ Difficulty swallowing
❑ Abdominal pain
❑ Nervousness
❑ Tension
❑ Other:_________________

Who is your employer? ____________________________ Occupation:___________________________

What activities does your work require? ____

____

Have you missed time from work? ❑ Yes ❑ No

If yes, how many days did you miss? ____

Were you released from work by a Doctor? ❑ Yes ❑ No

If yes, by what Doctor? ____

Dates of Release:_______ to _______ ❑ Part-Time off work ❑ Full-Time off work ❑ Unable to work since accident

Did you seek medical help immediately or soon after the accident? ❑ Yes ❑ No

If yes, how did you get there? ❑ Someone else drove me ❑ Ambulance

❑ Drove my own car ❑ Police

❑ Other:____

Doctor #1 / Hospital and or Clinic Seen:____ **Date Seen:**_________

Were you examined? ❑ Yes ❑ No

Were X-Rays Taken? ❑ Yes ❑ No

Did you receive treatment? ❑ Yes ❑ No

If yes, what treatment was provided to you? ❑ Bed Rest ❑ Brace ❑ Physiotherapy

❑ Adjustments ❑ Medications ❑Other:_________

What benefits did you receive from the treatment(s)? ____

Date of Last Treatment:____

Doctor #2 / Hospital and or Clinic Seen:____ **Date Seen:**_________

Were you examined? ❑ Yes ❑ No

Were X-Rays Taken? ❑ Yes ❑ No

Did you receive treatment? ❑ Yes ❑ No

If yes, what treatment was provided to you? ❑ Bed Rest ❑ Brace ❑ Physiotherapy

❑ Adjustments ❑ Medications ❑Other:_________

What benefits did you receive from the treatment(s)? ____

Date of Last Treatment:____

Doctor #3 / Hospital and or Clinic Seen:____ **Date Seen:**_________

Were you examined? ❑ Yes ❑ No

Were X-Rays Taken? ❑ Yes ❑ No

Did you receive treatment? ❑ Yes ❑ No

If yes, what treatment was provided to you? ❑ Bed Rest ❑ Brace ❑ Physiotherapy

❑ Adjustments ❑ Medications ❑Other:_________

What benefits did you receive from the treatment(s)? ____

Date of Last Treatment:____

Did you have any physical complaints **JUST BEFORE THE ACCIDENT?** ❑ Yes ❑ No

If yes, please describe in detail:____

PRIOR to this accident, did you ever have symptoms similar to what you are experiencing now? ❑ Yes ❑ No

If yes, please explain *(briefly include past falls/injuries/accidents/surgeries/etc):*_________________________

____

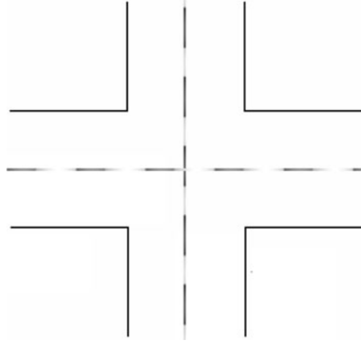
Do you notice any activities of your daily routine that is different **NOW** than from **BEFORE** the accident? ❑ Yes ❑ No

Those you are UNABLE to do:____

Those that are PAINFUL to do:____

Those that are DIFFICULT to do:____

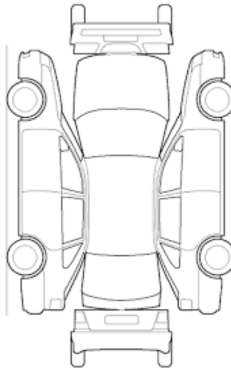
Please use this diagram to show how the accident happened ➔



Name of street or road on which the accident occurred: ____

Nearest cross street or intersection: ____

Please use this diagram to show the damages to your car ➔



Do you have an attorney retained for this case? ❑ Yes ❑ No

Attorney's Name:________________________________ Firm:___________________________________

Address:________________________________ City:__________________ State:______ Zip:_________

Insurance Information

✪ **Motor Vehicle Insurance Company**:____

Adjustor's Name:____Phone #:____________________________

Claim #:__________________ Policy #:_________________ Policy Holder:______________________________

✪ **At Fault or Other Insurance Company**:____

Adjustor's Name:____Phone #:____________________________

Claim #:__________________ Policy #:_________________ Policy Holder:______________________________

✪ **Your Private Insurance Company**:____

Adjustor's Name:____Phone #:____________________________

Claim #:__________________ Policy #:_________________ Policy Holder:______________________________

____ ____

Signature of Patient, Parent if Minor, or Representative for Patient | Please Print Name of Patient, Parent if Minor, or Representative for Patient

____ ____

Date of Signature | Relationship to Patient (Self, Parent, Representative, etc.)