Patient Information Form

Please completely fill out this form for all patients and attach to the front of every new file

PATIENT NAME _____

ADDRESS _____

_____

PHONE NUMBER _____

D.O.B. _____

S.S.N. _____

DIAGNOSIS _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

____AUTO ACCIDENT **____WORKER'S COMPENSATION**

P.I.P. OR W.C. INSURANCE CO. _____

INSURANCE ADRESS _____

_____

DATE OF ACCIDENT _____

CLAIM NUMBER _____

ATTORNEY NAME _____

ADDRESS _____

_____

*****PLEASE NOTE*****

A heath insurance form must also be filled out for every health and auto accident claim

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank You!

Name_____ Sex_____ Marital Status _____ Date of Birth_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Occupation_____ *How did you hear about our office?_____

Social Sec. #_____ Alternate Phone_____ Company Name_____ Location_____

Do you smoke? ____Yes____No Consume Alchohol ____Yes ____No Are you: Right Handed or Left Handed ?

Current accident information:

Date of accident: _____ Time of accident: _____AM _____PM

Were you the: ___Driver; ___Front Passenger; ___Lt. Rear Passenger; ___ Rt. Rear Passenger

Were you wearing a seatbelt: ___Yes ___No

What street were you on at the time of the accident: _____

What city/town were you in at the time of the accident: _____

What was the speed of your vehicle at the time of the accident: _____

What was the speed of the vehicle that hit you at the time of the accident: _____

What was the make and model of the vehicle you were in: _____

What was the make and mode of the vehicle that hit you: _____

Where was your vehicle hit [check one]:

___Front; ___Rear; ___Right front; ___Right Center

___Right rear; ___Left front; ___Left center; ___ Left rear

If your vehicle was stopped, how far was it pushed as a result of the impact: _____

At the point of the impact were you looking: ___ Forward; ___Right; ___Left

Were you [check one]: ___Aware of the impact; ___Surprised by the impact

Did you hit your head on impact: ___No ___Yes; if yes then on what: _____

Did any other body part hit anything in the vehicle: ___No ___Yes; if yes then please explain:

_____

Were you unconscious as a result of the injury: ___No ___Yes; if yes how long:
_____

Were you bleeding as a result of this injury: ___No ___Yes; if yes please describe:
_____

Please describe the pain you experienced immediately after the accident:
_____
_____
_____

Since the injury are your symptoms ___Improving? ___Getting Worse? ___Same?

Did the police go to the accident: ___Yes ___No

Did you go to the hospital: ___ Yes ___ No

If yes what hospital _____
Did you go to the hospital by ambulance: ___No ___Yes
If you drove to the hospital then the date_____ and time_____
At the hospital were x-rays taken: ___No ___Yes; If yes then of what _____
_____

Were any other tests performed: ___No ___Yes; if yes then of what tests and the results
_____

Was there any fractures seen on x-ray: ___ No ___Yes; if yes then where;_____
_____

What were you told by the emergency room doctor at the hospital in regard to your injuries. (what did he/she say happened to you) _____
_____

Have you seen any other doctor for these injuries: ___ No ___Yes
If yes, what is the doctors name: _____
What was the doctor's diagnosis: _____
_____

What was this doctors treatment: (list any medications given)_____
_____
_____

Have you ever had any complaints in the involved area before? ____Yes ____No
If yes, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ____Yes ____No

Were you ever involved in a motor vehicle accident prior to this accident? ____Yes____No

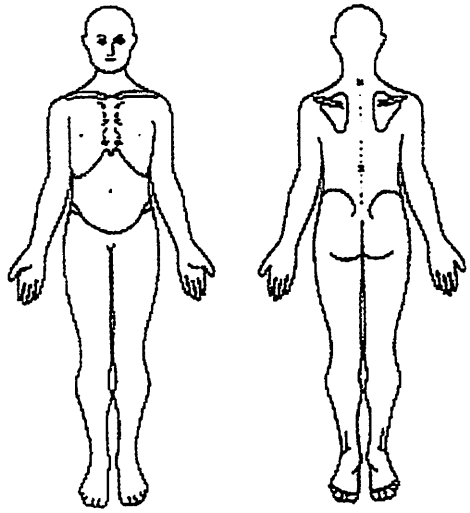
If yes, How many?____
What was/were the date(s) of the accident(s)_____
Were you injured from the accident? (If yes, explain)_____
Were you treated for the injuries? (If yes, where were you treated?)_____
How long did you receive treatment?_____Did you have pain after the treatment?_____

Describe your main area of pain:

_____

_____

Please mark your areas of pain on the figures below:



On a pain scale of 1-10 (with 0 = no pain and 10 being unbearable pain)

0__/__/__/__/__/__/__/__/__/__/__10

1 2 3 4 5 6 7 8 9 10

What is the estimated percentage of time you experience the pain?

0% _____/_____/_____/_____100%

(intermittent) 25%(occasional) 50% (frequent) 75% (constant)

Describe you second area of pain:

_____

_____

On a pain scale of 1-10 (with 0 = no pain and 10 being unbearable pain)

0__/__/__/__/__/__/__/__/__/__/__10

1 2 3 4 5 6 7 8 9 10

What is the estimated percentage of time you experience the pain?

0% _____/_____/_____/_____100%

(intermittent) 25%(occasional) 50% (frequent) 75% (constant)

Describe you third area of pain:

_____

_____

On a pain scale of 1-10 (with 0 = no pain and 10 being unbearable pain)

0__/__/__/__/__/__/__/__/__/__/__10

1 2 3 4 5 6 7 8 9 10

What is the estimated percentage of time you experience the pain?0%

_____/_____/_____/_____100%

(intermittent) 25%(occasional) 50% (frequent) 75% (constant)

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

Because of my back:

- ❑ I stay at home most of the time
- ❑ I change position frequently to try and get my back comfortable
- ❑ I walk more slowly than usual
- ❑ I am not doing jobs that I usually do around the house
- ❑ I use a handrail to get upstairs
- ❑ I lie down to rest more often
- ❑ I stay in bed most of the time
- ❑ I have to hold on to something to get out of an easy chair
- ❑ I try to get other people to do things for me
- ❑ I get dressed more slowly than usual
- ❑ I have trouble putting on my socks
- ❑ I only stand up for short periods of time
- ❑ I sit down for most of the day
- ❑ I try not to bend or kneel down
- ❑ My back is painful almost all of the time
- ❑ I have trouble sleeping
- ❑ I find it difficult to turn over in bed
- ❑ My appetite is not very good
- ❑ I only walk short distances
- ❑ I am more irritable and bad tempered with people than usual

Check symptoms you have noticed since the accident:

____Headache	____Dizziness	____Depression	____Fatigue
____Stomach Upset	____Light Bothers Eyes	____Buzzing in Ears	____Diarrhea
____Neck Pain	____Head seems too Heavy	____Loss of Memory	____Feet Cold
____Neck Stiff	____Pins and Needles in Arms	____Ears Ring	____Hands Cold
____Fainting	____Sleeping Problems	____Loss of Balance	____Back Pain
____Face flushed	____Pins and Needles in Legs	____Constipation	____Tension
____Nervousness	____Numbness in Fingers	____Loss of Smell	____Fever
____Irritability	____Numbness in Toes	____Loss of Taste	____Chest Pain
____Cold Sweats	____Shortness of Breath		

Vomiting: ___No ___Yes; if yes, explain _____

Vertigo (room spins around you): ___No ___Yes

Bladder dysfunction: ___No ___Yes; if yes explain _____

Bowel dysfunction: ___No ___Yes; if yes explain _____

Are there any other problems you are experiencing since the accident?

_____

If you have headaches circle the appropriate responses (see below for descriptions of ratings):

Front of Head: Grade – 1 2 3 4	Side – Right Left Both	Frequency – 1 2 3 4
Side of Head: Grade – 1 2 3 4	Side – Right Left Both	Frequency – 1 2 3 4
Back of Head: Grade – 1 2 3 4	Side – Right Left Both	Frequency – 1 2 3 4

Grade:

1 = minimal, the pain is annoying but is forgotten during activities of daily living
2 = slight, the pain is tolerated, but it does interfere with some daily activities
3 = moderate, the pain extensively interferes with activities including sleep, recreation, etc.
4 = marked, the pain prevents most activities, including sleep, recreation, etc

Side: If your pain is in the front or back is it to the right, left or both sides? Grade each headache separately if it occurs in more than one area.

Headache pain frequency:

1 = I have intermittent symptoms occurring up to 25% of my awake time
2 = I experience occasional symptoms between 25-50% of the time
3 = Pain is frequent and occurs between 50-75% of the time
4 = I have constant pain occurring between 75-100% of my awake time

PERSONAL INJURY INSURANCE INFORMATION (REQUIRED)

Your Automobile Insurance Company:

Name of Company_____Phone_____

Address_____

Claim #_____Has your insurance company been notified of the accident? Yes or No

****

Driver Information (If you were not driving and the driver is the owner of the vehicle):

Name of driver_____Phone_____

Address_____

Driver's Automobile Insurance Company (Only fill in if you were a passenger and do not have automobile insurance of your own)

Name of Company_____Phone_____

Address_____

Policy #_____Has the insurance company been notified of the accident? Yes or No

****

Your Health Insurance Information:

Name of Company_____Policy #_____

Are you covered by Medicare? Yes or No If yes, what is your insurance number?_____

****

Advising Attorney Information:

Name of Attorney_____Phone_____

Address_____

****

Assignment of Benefits by a Patient to a Physician:

I hereby assign to my physician all benefits for such services to which I am entitled under my Personal Injury Protection and/or Medical Payments coverage, and request my insurance company to pay any such benefits directly to my physician upon submission of any claim.

Signed_____Date_____