PATIENT INFORMATION

File#:_____

Name _____ **Today's Date** _____

Date of Birth _____ Height _____ Weight _____ Dominant Hand? R L

Address _____ City _____ Zip _____

Phone 1 _____ Phone 2 _____ Occupation _____

Emplyr: _____

SSN: _____Email _____ DL# _____

Date of Loss/Accident? _____

_____

Your Health Insurance _____ Memb ID#:_____

Address _____ City _____ Zip _____

Phone _____

Your Car Insurance Co _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

Medical Payments Coverage? _____ Uninsured Motorist Coverage? _____

Other Driver's Car Insurance Co _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Claim # _____ Accepted liability? [ ] Yes [ ] No

What Law Firm Represents You? _____

Address _____ City _____ Zip _____

Your Lawyer's Name? _____ Phone _____

What is the property damage (repair amount) of your car? $ _____

Date you *first* saw any Doctor after accident _____ Who? _____

Most recent date you saw a doctor for this accident? _____

Cost of all medical treatment since the accident? $ _____

Have you missed work because of the accident? [ ] Yes [ ] No Explain: _____

_____

File#:_____

Health History

Are you taking any of these medications?

[ ] Nerve pills [ ] Pain killers [ ] Aspirin/Ibuprofen/Tylenol/Aleve [ ] Muscle Relaxers [ ] Stimulants [ ] Blood Thinners [ ] Insulin
[ ] Tranquilizers [ ] Other: _____

Do you now or have you ever had any of these conditions?

Y N Heart attack/stroke	Y N Heart surgery/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral valve prolapse	Y N Artificial valves
Y N Alcohol/Drug abuse	Y N Venereal disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/TB	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back problems	Y N Artificial Bones/Joints	Y N Arthritis

List any previous accidents/injuries:

_____

_____

List any other serious medical conditions you may have or ever had:

_____

_____

_____

List any allergies you may have:

_____

_____

List previous surgeries with dates:

_____

_____

Take Vitamin/Nutritional supplements? List:

_____

Significant Family Medical History:

_____

_____

Are you pregnant? Y N **LMP:** _____ **Taking Birth control pills?** Y N **Type/How Long?** _____

Are you on any special diet? Y N How long? _____ **wks/mos/yrs Describe:**

_____

Do you smoke? Cigarettes? Y N **Cigars?** Y N **Pipe?** Y N **How many/How Often?** _____

Authorization for Treatment: *"I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information provided."*

*Signature*_____ *Date:* _____

Assignment of Benefits/Direct Payment to Provider: "*I hereby authorize assignment of my insurance rights and benefits and order any insurance company making payments on my behalf to do so directly to the provider."*

*Signature*_____ *Date:* _____

File#:_____

Name _____ **Today's Date** _____

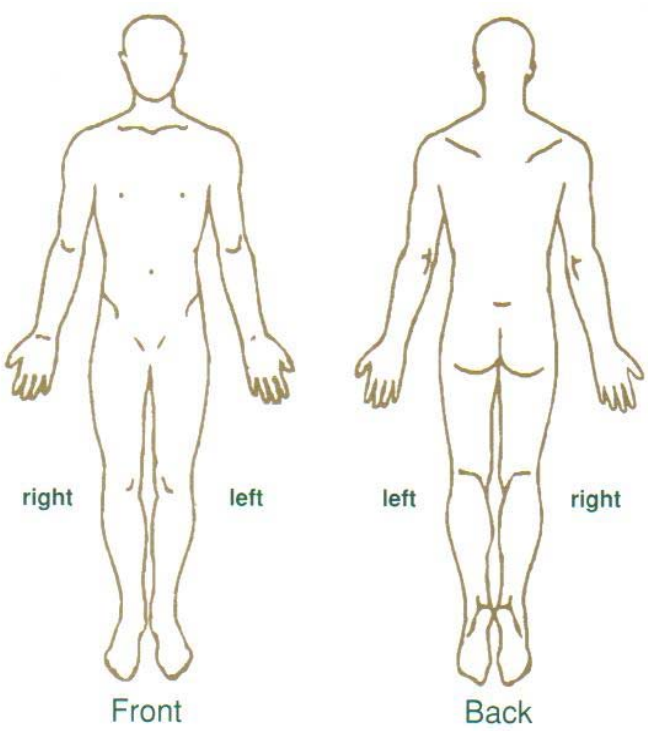
Tell us about your condition:

Height _____ Weight _____ Dominant Hand? R L

Please mark area(s) of pain or discomfort on the figures below. Mark all areas with a descriptive symbol and a number for severity of pain or distress on a 1 (minimal discomfort) to 10 (excruciating pain) scale.

Description: Numbness NNN, Pins & Needles PPP, Burning BBB, Aching AAA, Stabbing SSS, Electric EEE

Other: _____



File#:_____

Auto Accident History

Date and time of accident: _____ _____ [ ] AM [ ] PM

Were you the [ ] Driver [ ] Front Passenger [ ] Rear Passenger left [ ] Rear Passenger middle [ ] Rear Passenger right

If a traffic violation was issued, to whom was it issued? To whom? _____

Number of people in the accident in your vehicle? _____

Did the police come to the scene? [ ] Yes [ ] No Did you file a police report? [ ] Yes [ ] No _____

Any witnesses? [ ] Yes [ ] No Were you wearing seat belt? [ ] Yes [ ] No

Airbags deploy? [ ] Yes [ ] No

In relation to the base of your skull, where was your headrest adjusted? [ ] Above at base of skull [ ] Below

What did your vehicle impact? [ ] Other vehicle [ ] Other _____

Did any part of your body strike anything in the vehicle? [ ] Yes [ ] No Explain: _____

_____

Year, make, model, color of the vehicle you were in: _____

Name of street or freeway and city you were in: _____

In which direction were you traveling? [ ] North [ ] South [ ] East [ ] West

What was the approximate speed of your vehicle on impact? _____ mph

Did the impact to your vehicle come from the [ ] Front [ ] Rear [ ] Right side [ ] Left side _____

At impact were you facing [ ] Right [ ] Left [ ] Forward [ ] Behind [ ] Leaning forward _____

Were you [ ] aware of impact or [ ] surprised by impact? Did you brace your body? [ ] Yes [ ] No

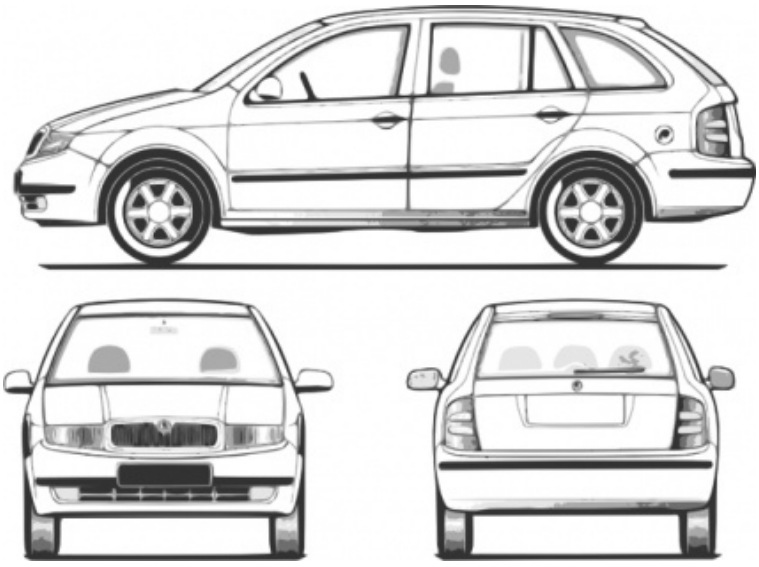
Year, make, model, color of other vehicle: _____

Briefly in your own words, describe the accident: _____

_____

_____

On the diagram below mark any areas of damage caused by the accident:



Do you have photos of the vehicle you were in? [ ] Yes [ ] No Other vehicle? [ ] Yes [ ] No

File#:_____

After the Accident

Did the accident render you unconscious? [ ] Yes [ ] No If yes, how long? _____

After the accident did you feel woozy, dizzy, foggy, light headed or out of sorts? [ ] Yes [ ] No

Do you have any visible abrasions, bruises, or cuts? [ ] Yes [ ] No Where? _____

_____

Please describe how you felt immediately after the accident: _____

_____

_____

Were you taken to the hospital via ambulance? [ ] Yes [ ] No If yes, where? _____

Have you seen any other doctor since the accident? [ ] Yes [ ] No Please list below, use other side for more

Doctor Name	Date	List X-rays, Tests, Treatment, Prescriptions, etc

Is your condition [ ] the same [ ] getting better or [ ] getting worse since the accident?

Please list any activities that have been affected or limited because of the accident:

Personal (dressing, hygiene, household chores, child care, etc):

_____

_____

_____

Social/recreational (reading, exercise, hobbies, family/friends, socializing, etc):

_____

_____

_____

Work (specific work functions, concentration, sitting, standing, driving, lifting, bending, etc):

_____

_____

_____