



Personal Injury/Accident/Medical History

Full Name: _____ Gender: M F Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Driver's License #: _____

Cell Phone: _____ Home Phone: _____

Who can we thank for Referring you to our office? _____

Accident Information

Date of Accident: _____ Time of accident: _____ AM PM

Your Vehicle: Year _____ Make _____ Model _____ Your Speed _____

Other Vehicle: Year _____ Make _____ Model _____ Their Speed _____

Accident Type: Rear-Ended Head-On Broad-Sided Damage to Your Vehicle: \$ _____ Theirs: \$ _____

Describe the Accident: _____

Accident Specifics (check/circle all that apply)

Job or work related injury?	Yes	No
Were you the...	Driver	Passenger
If the passenger, were you in the...	Front seat	Back seat
Were you wearing your seatbelt?	Yes	No
Impending collision, were you...	Aware	Unaware
	Braced	Relaxed
Did your head....	Strike object	Not strike object
	Break glass	
Did you experience...	Shock	Loss of consciousness
Did the airbag deploy?	Yes	No

(check/circle all that apply)

Immediately Following the Accident:

- Ambulance/Paramedics were called
- I was treated at the scene
- Transported to hospital by ambulance
- I went to hospital on my own
- I was diagnosed at hospital
- I was treated at the Hospital
- Medication was prescribed
- Follow-up was recommended

Other Doctors Seen:

- Orthopedist
- Psychiatrist
- Massage Therapist
- Neurologist
- Physical Therapist
- Chiropractor
- Other: _____

The Weather Was:

- Dry
- Sunny
- Raining
- Snowing/Ice
- Cloudy
- Foggy

The Road Was:

- Dry
- Wet
- Slick
- Packed with snow

Time of Day:

- Dawn
- Day
- Dusk
- Night

Describe your emotional and physical state *immediately following* the accident: _____

Describe your emotional and physical state during *the week following* the accident: _____

Symptomology

Describe the pain (constant, comes and goes, any tingling/numbness?, area of the body, etc.): _____

The pain started when _____

The pain is better when _____

The pain is worse when _____

How severe is your pain, on a scale from 1»10? _____

Does the pain radiate to other areas? If yes, where? _____

How do the following activities affect your pain? (check what applies to you)

	No change	Relieves	Increases
Sitting			
Walking			
Standing			
Lying down			
Looking up			
Looking down			
Lifting objects			

What activities could you do before that you can no longer do without pain? (hobbies, exercise, daily tasks, etc.): _____

What are your goals with receiving care for this injury? _____

Please check any daily activities that are impaired by your pain.

Climbing the stairs

Walking long distances

Standing

Getting up from chair/couch

Mood

Sleeping

Cleaning the house

Bending down

Getting dressed

Occupational History

Your Employer: _____ Your Job Title: _____

Are your job duties physically demanding? Yes No

Have you taken time off for this injury? Yes No

Are you doing office work or a lighter workload because of this injury? Yes No

Current job Satisfaction: _____ Highest Level of Education Completed: _____

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

Social History

- Are you:
- Single
 - Married
 - Divorced
 - Widowed

- Do you:
- | | |
|-------------------------|-----------------------------|
| Smoke | Not Smoke |
| Drink Alcohol | Not Drink Alcohol |
| Take Recreational Drugs | Not Take Recreational Drugs |

Any Children? Yes No How many? _____

Medical History:

List the physicians and other practitioners you have seen for this problem

List the medications you are currently taking (anything for this injury *and* any other meds. you take regularly)

Circle any treatments you've had for this injury

- | | |
|-------------------------|--------------------------|
| Ultrasound | Chiropractic |
| Massage | Osteopathy |
| Electrostimulation | Biofeedback |
| TENS unit | Trigger Point Injections |
| Body Mechanics Training | Epidural Injections |
| Strengthening Exercises | Back Brace |
| Aerobics | Acupuncture |
| Gravity Inversion | Neuropathy |

Circle the types of diagnostic testing preformed for this injury

- X-rays
- CT Scan
- Myelogram
- MRI Scan
- Discogram
- Bone Scan
- EMG

List Past Surgeries

List Past Hospitalizations

List previous back, neck and musculoskeletal problems

Check if you've had any of the following in the past 5 years

- Unexplained fevers
- Night sweats
- Weight loss of 10 lbs or more
- Loss of appetite
- Excessive fatigue
- Depression
- Anxiety
- Difficulty sleeping
- Unusual stress at home
- Unusual stress at work
- Easy bruising
- Excessive bleeding
- Lumps in neck, armpit or groin
- Chest pain or tightness
- Persistent or unusual cough
- Trouble breathing with exercise
- Trouble breathing while lying flat
- Coughing up blood

- Swollen ankles
- Stomach pain
- Change in bowel habits
- Persistent diarrhea
- Excessive constipation
- Dark black stool
- Blood in stool
- Pain/burning when urinating
- Blood in urine
- Need to urinate more at night
- Morning stiffness
- Persistent eye redness
- Muscle tenderness
- Dry eyes or mouth
- Skin rashes
- Joint pain or swelling

Females, do you have any of the following

- Vaginal bleeding other than your period
- Pap smear within the last two years
- Painful menstruation
- Back pain with menstruation

Do you have any current problems with:

- Anxiety
- Depression
- Irritability

Assignment of Benefits In Personal Injury Cases



I authorize **ProWellness Chiropractic (Freedom Chiropractic Corp.)** to receive payment from liable insurance companies, attorneys, or myself for all monies due on my account. I understand that all coverage in effect at the time of my injury will be billed. Any overpayments will be promptly returned to me. In the event that there is no valid coverage or that I have exceeded my insurance limit, I will remain responsible for charges incurred.

Further, I hereby authorize **ProWellness Chiropractic (Freedom Chiropractic Corp.)** or any of their employees to sign my name (we will call you to notify you this is happening) on the back of any draft or check which they receive from my insurance company for services rendered, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly.

All fees are based upon individual services rendered and may vary from visit to visit depending upon the doctor's specific recommendations.

Note: Unless all proper claim and insurance information is provided, the patient will be responsible for payment of care received after the first visit until the necessary information can be validated.

A charge of \$50 will be assessed for a missed appointment. This fee will require payment at the next visit. We require a 24-hour notice for cancellations.

If the case is not settled within 120 days of being released from active care, the patient will be responsible to begin making monthly payments until the balance is paid by the insurance company.

I agree to the terms above and acknowledge that in the event that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with **Pro Wellness Chiropractic (Freedom Chiropractic Corp.)** will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

I authorize my healthcare provider and/or any entity authorized by my healthcare provider including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

Name

Signature

Date



Personal Injury Case

Med Pay Sheet

Personal Information

Patient's Printed Name: _____ DOB: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Patients Primary Phone Number: _____ cell home work

Insurance Attorney Information

Patient's Insurance Company: _____ Patient's Policy Number: _____

Insurance Company of the Person at Fault: _____ Name of Agent: _____

Date of Accident: _____ Accident Type(circle one): Work Auto Slip/Fall at Business Other: _____

Address to Send Claims to: _____ City: _____ State: _____ Zip: _____

Insurance Company's Phone Number: _____ Agent's Phone Number: _____

Claim Number: _____ Have you hired an attorney? Yes No

Your Attorney's Name: _____ Your Attorney's Phone Number: _____

Your Attorney's Address: _____ City: _____ State: _____ Zip: _____