CONFIDENTIAL HEALTH INFORMATION

Eddy Chiropractic Clinic Inc.
443 Highland Ave
Williamstown, WV 26187
304-375-6000

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes **When?**

If so, whom?

Whom may we thank for referring you?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | **State/Province** | **ZIP/Postal Code** | **Home Phone** | **Spouse's Name**

Email Address | **Cell Phone** | **Child's Name and Age**

Emergency Contact | **Phone** | **Child's Name and Age**

Your Occupation | **Child's Name and Age**

Your Employer

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Address

City | **State/Province** | **ZIP/Postal Code** | **Work Phone**

Insurance Carrier | **Policy Number** | **Primary Care Provider's Name**

Insured's Social Security Number

Insured's Last Name | **Birth Date (MM/DD/YYYY)**

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | **Middle Name (or Initial)**

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

Version No. 01753838
© 2012 Paperwork Project. All rights reserved.

Patient name ______

1. **The symptom(s) that have prompted me to seek care today include:** ______

2. **And are the result of (darken circle):** ◯ An accident or injury
◯ Work ◯ Auto ◯ Other ______
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ______

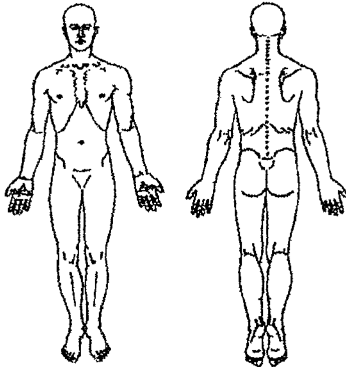
3. **Onset** (When did you first notice your current symptoms?) ______

4. **Intensity** (How extreme are your current symptoms?)
0 ◯◯◯◯◯◯◯◯◯◯ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? ______

6. **Quality of symptoms** (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other ______

7. **Location** (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) ______

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ______
What tends to lessen the problem? ______

10. **Prior interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other ______
◯ Physical therapy ◯ Massage ______

11. **What else should Eddy Chiropractic Clinic know about your current condition?** ______

12. **How does your current condition interfere with your:**

Work or career: ______

Recreational activities: ______

Household responsibilities: ______

Personal relationships: ______

13. **Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

Currently treating with Primary Care Physician Y N **Name of Physician** ______

a. Musculoskeletal (Had / Have)
◯ ◯ Osteoporosis ◯ ◯ Arthritis ◯ ◯ Scoliosis ◯ ◯ Neck pain ◯ ◯ Back problems ◯ ◯ Hip disorders — NONE ◯
◯ ◯ Knee injuries ◯ ◯ Foot/ankle pain ◯ ◯ Shoulder problems ◯ ◯ Elbow/wrist pain ◯ ◯ TMJ issues ◯ ◯ Poor posture — Initials ____

b. Neurological (Had / Have)
◯ ◯ Anxiety ◯ ◯ Depression ◯ ◯ Headache ◯ ◯ Dizziness ◯ ◯ Pins and needles ◯ ◯ Numbness — NONE ◯ Initials ____

c. Cardiovascular (Had / Have)
◯ ◯ High blood pressure ◯ ◯ Low blood pressure ◯ ◯ High cholesterol ◯ ◯ Poor circulation ◯ ◯ Angina ◯ ◯ Excessive bruising — NONE ◯ Initials ____

d. Respiratory (Had / Have)
◯ ◯ Asthma ◯ ◯ Apnea ◯ ◯ Emphysema ◯ ◯ Hay fever ◯ ◯ Shortness of breath ◯ ◯ Pneumonia — NONE ◯ Initials ____

e. Digestive (Had / Have)
◯ ◯ Anorexia/bulimia ◯ ◯ Ulcer ◯ ◯ Food sensitivities ◯ ◯ Heartburn ◯ ◯ Constipation ◯ ◯ Diarrhea — NONE ◯ Initials ____

f. Sensory (Had / Have)
◯ ◯ Blurred vision ◯ ◯ Ringing in ears ◯ ◯ Hearing loss ◯ ◯ Chronic ear infection ◯ ◯ Loss of smell ◯ ◯ Loss of taste — NONE ◯ Initials ____

g. Skin (Had / Have)
◯ ◯ Skin cancer ◯ ◯ Psoriasis ◯ ◯ Eczema ◯ ◯ Acne ◯ ◯ Hair loss ◯ ◯ Rash — NONE ◯ Initials ____

Consultation Notes

Doctor's Initials ______

Eddy Chiropractic Clinic Inc.

Version No. 91753638
© 2012 Paperwork Project. All rights reserved.

(Continued from previous page)

h. Endocrine

Had Have ○ ○ Thyroid issues | Had Have ○ ○ Immune disorders | Had Have ○ ○ Hypoglycemia | Had Have ○ ○ Frequent infection | Had Have ○ ○ Swollen glands | Had Have ○ ○ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ○ ○ Kidney stones | Had Have ○ ○ Infertility | Had Have ○ ○ Bedwetting | Had Have ○ ○ Prostate issues | Had Have ○ ○ Erectile dysfunction | Had Have ○ ○ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low libido | Had Have ○ ○ Poor appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden weight gain/loss (circle one) | Had Have ○ ○ Weakness | NONE ○ Initials ____

Patient name ____________

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	Illness	Had	Have	Illness
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____
○	○	Cancer			____
○	○	Chicken pox			____
○	○	Diabetes			____
○	○	Epilepsy			____
○	○	Glaucoma			____
○	○	Goiter			____
○	○	Gout			____
○	○	Heart disease			____
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	Treatment
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____

○	○	Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Eddy Chiropractic Clinic about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	Poor	Illnesses	Age at death	Cause of death: Natural	Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

19. Are there any other hereditary health issues that you know about? ____________

20. Social History

Tell Eddy Chiropractic Clinic about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ____
Coffee use	○ Daily	○ Weekly	How much? ____
Tobacco use	○ Daily	○ Weekly	How much? ____
Exercising	○ Daily	○ Weekly	How much? ____
Pain relievers	○ Daily	○ Weekly	How much? ____
Soft drinks	○ Daily	○ Weekly	How much? ____
Water intake	○ Daily	○ Weekly	How much? ____

Hobbies: ____________

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials

Eddy Chiropractic Clinic Inc.

Version No. 91753638
© 2012 Paperwork Project. All rights reserved.

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

Patient name ____________

22. What is the major stressor in your life? ____________ **23. How much sleep do you average per night?** ______ **Hours**

24. What is the type and approximate age of your mattress and pillow? ______ **25. What is your preferred sleeping position?** ______

26. Describe your typical eating habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ____________

28. In addition to the main reason for your visit today, what additional health goals do you have? ____________

Consultation Notes

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consent to Treat a Minor Child

Initials ____ **I hearby authorize the doctors and assistants at Eddy Chiropractic Clinic, Inc. to administer chiropractic care as deemed necessary to my (son / daughter) ____________.**

If the patient is a minor child, print child's full name: ____________

Doctor's Initials

Eddy Chiropractic Clinic Inc.

Signature ____________ Date (MM/DD/YYYY) ____________

Version No. 91753638
© 2012 Paperwork Project. All rights reserved.

CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION

By signing this form, you are granting consent to Eddy Chiropractic Clinic INC. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices (NPP) provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (304) 375.6000. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time, it is necessary for representatives of Eddy Chiropractic Clinic, INC to leave messages for patients. The purposes of these messages are to notify the patient that the doctor would like to discuss results, or to ask a patient to call Eddy Chiropractic Clinic, INC regarding an issue or concern, or to cancel/reschedule an appointment. At no time will a representative of Eddy Chiropractic Clinic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Preferred phone number to be contacted: (______)____________________

______approval to leave a message with detailed information

______leave a message with call back number ONLY

______________________________ ______________________

Signature Date

____

Patient Name (Please Print)

HIPAA FORM 2022

If you would like the option of being able to have your spouse, parent, or other individual to discuss your account with us please fill in the form below and sign. If our office does not have signed permission by you, we will be unable to honor any request for information from any of these parties. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Names authorized on account (list relationship), if no one is authorized, please write N/A below.

Name:______________________________ Relationship to Patient: ______________

Name:______________________________ Relationship to Patient: ______________

Name:______________________________ Relationship to Patient: ______________

___ Medical only
___ Financial only
___ All
___ No Consent

______________________________ ______________________

Patient Signature Date

____

Patient Name (print please)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:________________________________

Patient Date of Birth: ______________________ SS Number:_______________________________

I authorize the use and disclosure of the above individual's health information as described below.

The following individual or organization is authorized to make the PHI disclosure.

____

Person/Organization

____

Address

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

__ All medical records from (date ____________ to (date) ____________ ☐ All dates of service
__ Most recent history and physical
__ Most recent discharge summary
__ Office visits from (date ____________ to (date) ____________
__ Laboratory results from (date ____________ to (date) ____________
__ X-ray and imaging reports from (date ____________ to (date) ____________
__ X-ray and imaging disc from (date ____________ to (date) ____________
__ Consultation reports from (date ____________ to (date) ____________
__ Other ____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and/or treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual organizations:

Eddy Chiropractic Clinic Inc.
443 Highland Avenue, Williamstown, WV 26187
Phone: (304) 375.6000 Fax: (304)375.6043

The use or disclosure for which this request is made is: Review of medical records for diagnosis and/or treatment.

I understand that I may revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Eddy Chiropractic Clinic. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***This authorization will expire one year from the date signed***.

I understand that authorizing the disclosure of this individually identifiable health information (PHI) is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal privacy regulations.

I hereby authorize the use or disclosure of my PHI as described below.

____

Signature of patient or patient's legal representative *(Form MUST be completed before signing.)* **Date**

Printed name of patient's representative:________________________________

Relationship to the patient:____

EDDY CHIROPRACTIC CLINIC, INC.
Exercise Wellness Center
Dr. Steven L. Eddy
443 Highland Ave., Williamstown, WV 26187 • (304) 375-6000 • Fax (304) 375-6043

GOOD FAITH ESTIMATE & FINANCIAL RESPONSIBILITY WAIVER

In this office, our major concern is to assist you in maintaining overall good health. As a patient with insurance coverage, you should be aware that insurance policies can vary greatly in terms of coverage, limitations, covered services and referral requirements. **We strongly recommend that each patient contact his/her own insurance company to verify their individual coverages.** Per our contract with your insurance carrier, it is required that you, the patient, be personally responsible for the payment of your deductibles/copays/co-insurance and charges that may exceed your coverage, prior to receiving treatment.

If at any time you fail to present our office with your current insurance card(s), fail to secure any necessary referral to be seen in our office, do not have current authorization on record for treatment in our office, exceed visit limitations, or receive non-covered services, the charges incurred will become your responsibility.

Please refer to the list below for the pricing of common services offered in our office so that you are aware of what charges will apply in the event you are responsible. This is not a complete list of services/supplies, pricing can be obtained from any of our staff should you have further concerns.

SERVICES		STANDARD CHARGES (Insurance)	CHUSA DISCOUNT ($49 enrollment fee)	PATIENT OPTIONS (no enrollment fee - 1/1/22)
Examinations	99202/99212	$75.00/$65.00	$60.00/$40.00	$60.00/$40.00
Detailed Examinations	99203/99213	$125.00/$100.00	(Worker's Compensation & Personal Injuries)	
X-rays	Multiple codes	$75.00 and up	$20.00 per view taken	$20.00 per view taken
Spinal Manipulation	98940/98941/98942	$40.00/$50.00/$60.00	$30.00	$30.00
Electrical Stim.	97014	$25.00	$15.00	$15.00
Ultrasound	97035	$25.00	$15.00	$15.00
Cold Laser	97039	$25.00	$15.00	$15.00
Extremity Manipulation	98943	$30.00	$25.00	$25.00

Charges may vary based on your diagnosis determined upon your visit. Our staff will be happy to assist you with any questions you may have about your insurance benefits.

I have read and agree to receive the care recommended and accept financial responsibility for services provided.

______________________________ ______________________

Patient Signature Date

______________________________ ______________________

Witness Signature Date

Med Pay Information

A lot of people have medical benefits (MedPay) included in their automobile policies, and don't realize the benefits of using it. Our office highly recommends that you use your medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who was at fault.

Here are 5 major reasons why we recommend that you utilize your medpay.

1. Medpay is like health insurance - using it does not cause your rates to increase. If your rates increase it is not because you filed your medpay, it is due to other circumstances not affiliated with your medical claim.
2. Filing your medpay doesn't relieve the other party from having to pay in full for your loss. Medpay simply makes payments for your medical bills on your behalf as you receive treatment and then collects the money owed to your insurance company from the at fault insurance company upon settlement of your claim Secondly, if the other drivers liability insurance refuses to make payment to you for whatever reason, filing your medpay will help to ensure that you are not left with all of the medical bills to pay out of your pocket.
3. If you have medpay coverage and choose not to file it, then you are paying for an option every month on your premium, but not receiving any benefits.
4. As long as our office is filing your medpay and your insurance company is continuing to cover your charges, you will not be required to make payments out of your pocket on your personal injury account in our office.
5. Let your insurance company work for you; by involving your insurance company, even when the accident was not your fault, you ensure that there is someone else helping look out for your best interest.

Please be aware that it is our desire to provide you with the best care available for your condition and to assist you in maintaining overall good health. We will be happy to assist you in answering any questions you may have and explaining to you all options that are available in a personal injury claim.

VEHICLI ACCIDENT INFC ƖMATION

PATIENT INFORMATION

Date______________

Patient Name______________________________

Date of Accident______________ Time of Accident______________ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:______________________________

____

____

____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?__________

ACCIDENT SITE

Road/Street Name______________

City/State______________

Nearest intersection with road/street______________

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other ______

Which direction were you headed? ______________

Speed you were traveling?______________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle______________

Which direction was other vehicle headed?______________

Speed other vehicle was traveling______________

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain______________________________

____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain______________

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other__________

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?______________

#20546 – © 2004 Medical Arts Press® 1-800-328-2179

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?________________

Please describe how you felt immediately after the accident:

____

____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital________________________ Name of doctor________________________

Diagnosis____

____

Treatment received____

X-rays taken____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?__________

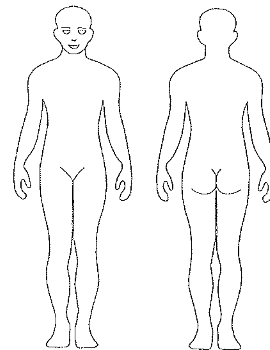
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain
☐ Back pain
☐ Back stiffness
☐ Chest pain
☐ Dizziness
☐ Ear buzzing
☐ Ear ringing
☐ Fatigue
☐ Feet/toe numbness
☐ Hand/finger numbness
☐ Headaches
☐ Irritability
☐ Jaw problems
☐ Leg pain
☐ Memory loss
☐ Nausea
☐ Neck pain
☐ Neck stiff
☐ Shortness of breath
☐ Sleep difficulty
☐ Stomach upset
☐ Tension
☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)______

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other____________

How often do you have this pain?________________________________

Is it constant or does it come and go?________________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ____________________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

PERSONAL INJURY INFORMATION QUESTIONAIRRE

Patient Name: ____

Date of Accident: ______________________

1. Name of your automobile insurance company: __________________

Name & phone # of your agent: ______________________________

Name of policy holder: ____________________________________

Policy # ____

Have you reported this accident to your insurance company? _________

Have you opened a med pay account with your insurance? __________

Claim # ______________________________________

Address to send claims to: _____________________________________

____

2. Name of your health insurance company? ______________________
(Please give us a copy of your insurance card if you would like us to bill them)

3. Have you retained an attorney regarding this accident? ______________

Attorney's name & phone #: ___________________________________

4. Name of at-fault party's insurance company? ______________________

Name of policy holder: ____

Name & phone # of the adjuster handling claim.____________________

____

Claim # ____

Have you settled with this company yet? ___________________________