



Confidential Patient Health Record

PERSONAL INJURY PATIENT HISTORY

Please check all appropriate responses:

Today's Date: ____/____/20__

Last Name: _____

First Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Cell phone: (____) _____ - _____

Birth Date: ____/____/____

Sex: male female

E-mail: _____@_____.

Check the box to the left if you would like to receive Dr. Joe's Newsletter at the email address specified above.

Marital status: Single Married Divorced
 Widowed Separated

Title: Mr. Ms. Mrs. Miss
 Dr. Rev. Hon.

Social Security # ____-____-____

Work Status unemployed full time
 part time retired
 disabled / not working
 self-employed

Occupation: _____

Employer: _____

Business Phone: (____) _____ - _____

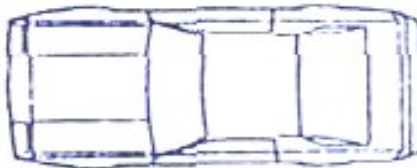
Address: _____

City: _____ State: _____ Zip: _____

- Date of Accident: ____/____/____ 2. Time of Accident: _____ AM/PM
- Driver of Car: Self Other: _____
- Where were you seated? Driver's seat Other: _____
- Who owns the car? _____
- Year & Model of your car. _____
- Year & Model of the other car. _____
- What was the approximate damage done to your car? \$ _____
- Visibility at time of accident: poor fair good other: _____
- Road conditions at time of accident: icy rainy wet clear dark other (describe): _____

II. Where was your car struck?

FRONT



REAR

In your own words, please describe accident _____

- Type of Accident: Rear impact (hit from behind) Head-on collision Broad-side collision
 Front Impact Rear-ended car in front Non-collision

Office use only:

ROF Date: _____ Visit type: _____

Acct ID _____ Case ID _____ Scanned Date _____ Completed Date _____ Int. _____

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

14. Did you see the accident coming? yes no

15. Did you brace for impact? : yes no

16. Were seatbelts worn? yes no

17. Does your car have headrests? yes no

18. If yes, what was the position of those headrests compared to your head before the accident? Top of headrest even with **bottom** of head Top of headrest even with **top** of head Top of headrest even with **middle** of neck

19. Was your car braking? yes no

20. Was your car moving at the time of the accident? yes no

21. If yes, how fast would you estimate you were going? _____mph

22. How fast would you estimate the other car was going? _____mph

23. Head/Body position at the time of impact: Head turned left/right Body straight in sitting position
 Head looking back Body rotated right/left Head straight forward Other _____

24. As a result of the accident you were: Rendered unconscious In shock Dazed, circumstances vague
Other: _____

25. Were you wearing a hat or glasses? yes no

26. Could you move all parts of your body? yes no

27. If no, what parts couldn't you move and why?

28. Were you able to get out of the car and walk unaided? Yes No

29. If no, why not? _____

30. Did you get any bleeding cuts? Yes No If yes, where? _____

31. Did you get any bruises? Yes No If yes, where? _____

32. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

33. Please check symptoms apparent since the accident:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Pain behind Eyes |
| <input type="checkbox"/> Eyes Light Sensitive | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Anxious | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Neck pain/Stiffness | <input type="checkbox"/> Tension |

- Diarrhea
- Nervousness
- Facial Pain
- Mid back pain
- Dizziness

- Numbness in fingers
- Loss of taste
- Breath shortness
- Ringing/Buzzing
- Cold hands

- Constipation
- Cold Sweats
- Clicking or Popping Jaw
- Other _____

34. Occupation/Job Duties: _____

35. Employer: _____

36. Have you missed time from work: yes no

37. If yes, full time off work: _____ to _____

38. If yes, part time off work: _____ to _____

39. Did you seek medical help immediately after the accident? yes no

40. If yes, how did you get there? Ambulance Police Someone else drove me Drove own car
Other: _____

41. Doctor #1: Name: _____

42. First Visit Date: _____

43. Were you examined? yes no

44. Were X-rays taken? yes no

45. Did you receive treatment? yes no Medications Braces Collars

46. If yes, what kind of treatment did you receive? _____

47. What benefits did you receive from the treatment? _____

48. Date of last treatment: _____

49. Doctor #2: Name: _____

50. First Visit Date: _____

51. Were you examined? yes no

52. Were X-rays taken? yes no

53. Did you receive treatment? yes no

54. If yes, what kind of treatment did you receive? _____

55. What benefits did you receive from the treatment? _____

56. Date of last treatment: ___/___/___

57. Do you have an attorney on this claim? yes no

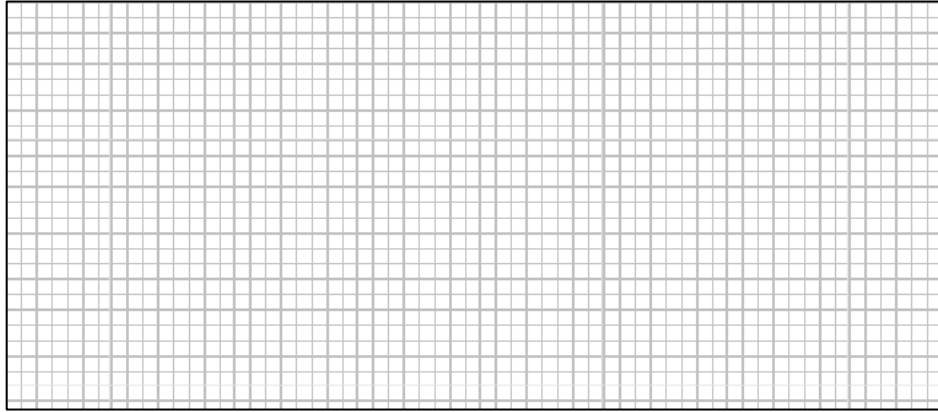
58. If yes, who? _____

Address _____

City _____ State _____

Zip _____ Phone (____) _____

Illustrate below how the accident happened:



Past Medical History: Please check and Describe:

- None related to current complaints Hospital or operation Auto Accident Work Accident Illness
Other _____

Describe: _____

Family History: Please check if any family member has suffered from:

- Tuberculosis Mental Illness Gout Hypertension Kidney Disease Epilepsy Allergies
Cancer Heart Attack Spinal Disorder Diabetes Arthritis Migraines
Other, list: _____

Personal History: Please check if it applies, describe.

- Number of Children _____ Number of Children at home _____
Employed Spouse yes no
Are you pregnant? yes no not sure
Medications, describe _____
Disease, describe _____
Other, describe _____

SYSTEM REVIEW: Please check the symptoms you know you have

Genitourinary System

- Bladder trouble Painful urination Excessive urination Discolored urine Scanty urination

Gastro-Intestinal System

- Poor appetite Difficult swallowing Vomiting food Constipation Hemorrhoids Weight trouble
Excessive hunger Excessive thirst Abdominal pain Black stool Liver trouble Difficult chewing
Nausea Diarrhea Bloody stool Gall bladder trouble

Nervous System

- Numbness Dizziness Muscle jerking Confusion Loss of feeling Fainting Convulsions
Depression Paralysis Headaches Forgetfulness

Cardio-Vascular System

- Chest pain Persistent Cough Rapid heartbeat Lung problems Pain over heart Coughing
phlegm High blood pressure Varicose veins Difficulty breathing Coughing blood Heart
problems Other

Eye, Ear, Nose and Throat System

- Eye strain Eye inflammation Ear pain Ear noises Hearing loss Nose pain Nose discharge
Breathing difficulty Sore mouth Sore throat Speech difficulty Dental problems Vision
problems Ear discharge Nose bleeding Sore gums Hoarseness

Current Chief Complaint(s): Please check all appropriate complaint areas.

SPINE

Neck Mid back Low back Pelvis

UPPER EXTREMITY

Shoulder R/L Wrist R/L Arm R/L Forearm R/L Elbow R/L Hand R/L

LOWER EXTREMITY

Hip R/L Leg R/L Thigh R/L Ankle R/L Knee R/L Foot R/L

OTHER (describe): _____

Subjective Pain Level:

On a scale of 1-10 (10 being the worst)
Please check your current pain level.

NORMAL

0

LOW PAIN

1 2 3

MODERATE PAIN

4 5 6

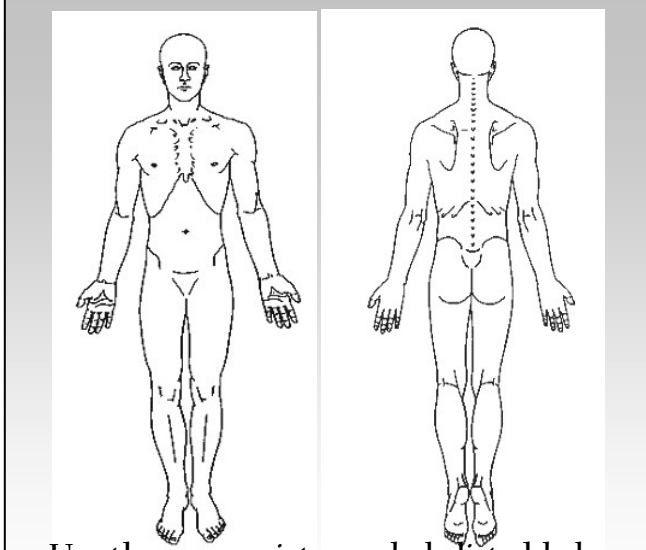
INTENSE PAIN

7 8 9

EMERGENCY

10

Mark the areas on your body where
you feel the described sensations.
Mark stress points where the pain radiates.
Include all your affected areas.



Use the appropriate symbols listed below.

X (NUMBNESS) + (BURNING)

O (PIN & NEEDLES) = (STABBING)

Patient's Signature: _____ Date ____ / ____ / ____

Witness: _____

Consent for Treatment

I, the undersigned, hereby authorize the Doctors of Health Plus Wellness and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature _____ Date ____ / ____ / ____

Witness _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date ____/____/_____
Witness _____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Health Plus Wellness the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ Date ____/____/_____
Witness _____

Attorney Representation and Protection of Balance

I, the undersigned patient am directing my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Patient's Signature _____ Date ____/____/_____
Witness _____

Consent for Treatment of Minor

I hereby authorize the Doctors of Health Plus Wellness and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____ (indicate relationship of child),
_____ (Child's name)

Guardian's Signature _____ Date ____/____/_____
Witness _____

ASSIGNMENT OF BENEFITS AND DOCTOR'S LIEN

I, _____, hereby authorize Health Plus Wellness Centers to release to you a full report of findings, diagnosis, treatment and prognosis for me regarding injuries sustained in the accident in which I was involved on _____.

I direct you as my attorney to pay directly to Health Plus Wellness Centers all moneys owed to the doctor in consequence of this accident, as well as any other sums outstanding with the doctor. I authorize that these funds be withheld from any settlement made in this case.

I further give a lien on my case to Health Plus Wellness Centers against any and all proceeds of the settlement, judgment or verdict which may be paid to me or to you as my attorney as a result of the injuries sustained in the accident and treated by Health Plus Wellness Centers.

This lien does not supplant my own responsibility of outstanding medical bills, but is given as protection for the doctor and in consideration for this willingness to await delayed payment. I understand that payment of all outstanding fees to Health Plus Wellness Centers are payable upon demand and all are not contingent on the receipt of an award through settlement, judgment or verdict.

As a further inducement to accept a lien for my medical treatment, I hereby authorize and direct my attorney to communicate any offers of settlement to my doctor, and to discuss my case openly and fully with him/her. This authorization and direction is made in consideration for the acceptance of this lien. I understand that the doctor will send a copy of this authorization to my attorney, and direct my attorney to honor this obligation to communicate with my doctor. I also authorize my attorney to send my doctor, upon settlement, a copy of the settlement statement.

Patient

Date

As the attorney of record for the above-named patient, I hereby agree to observe the terms of this agreement, and to withhold from any award in this case such sums as are required for the adequate protection of Health Plus Wellness Centers.

Attorney

Date

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