

*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: _____@_____.

Marital status: ☐ Single ☐ Married ☐ Divorced☐ Widowed ☐ SeparatedTitle: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss☐ Dr. ☐ Rev. ☐ Hon.

Social Security # ____ - ____ - ____

Work Status ☐ unemployed ☐ full time☐ part time ☐ retired☐ disabled-notworking☐ self-employed

Occupation: _____

Employer: _____

Business Phone: (____) ____ - ____

Address: _____

City: _____ State: _____ Zip: _____

1. Date of Accident: ____/____/____ 2. Time of Accident: _____ AM/PM

3. Driver of Car: ☐ Self ☐ Other: _____4. Where were you seated? ☐ Driver's seat ☐ Other: _____

5. Who owns the car? _____

6. Year & Model of your car. _____

7. Year & Model of the other car. _____

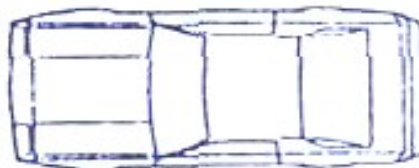
8. What was the approximate damage done to your car? \$ _____

9. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____10. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other

describe): _____

11. Where was your car struck?

FRONT



REAR

In your own words, please describe accident _____

12. 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:

- | | | |
|---|--|--|
| ☐ Headache | ☐ Loss of balance | ☐ Pain behind Eyes |
| ☐ Eyes Light Sensitive | ☐ Cold feet | ☐ Sleeping problems |
| ☐ Fainting | ☐ Chest pain | ☐ Loss of smell |
| ☐ Numbness in toes | ☐ Anxious | ☐ Fatigue |
| ☐ Loss of memory | ☐ Low Back Pain | ☐ Depression |
| ☐ Irritability | ☐ Neck pain/Stiffness | ☐ 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

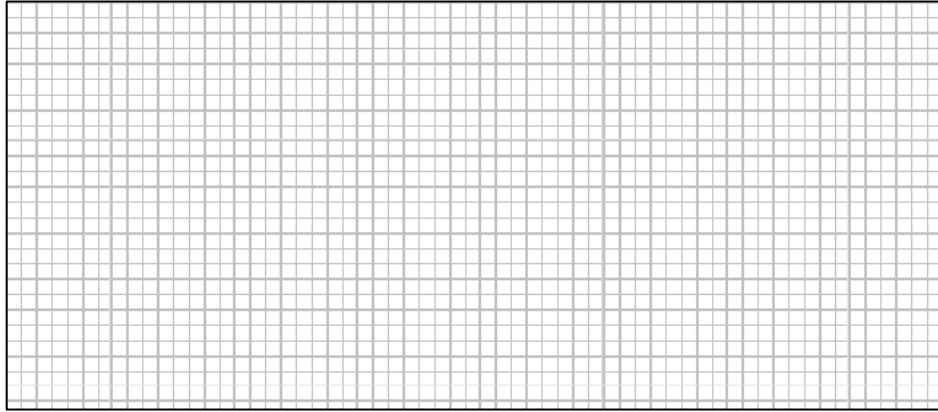
58. If yes, who? _____

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

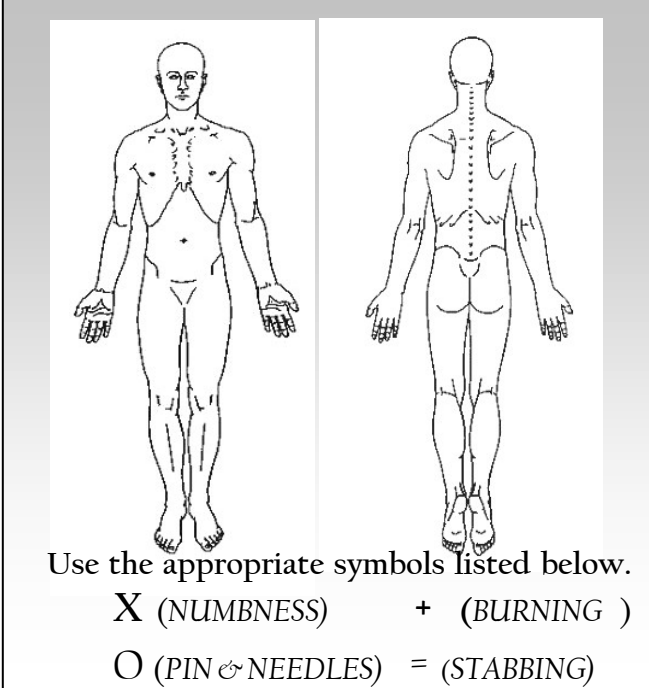
INTENSE PAIN

☐ 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 _____

AGREEMENT TO DEFER COLLECTION OF PAYMENT

I _____ (the “**Patient**”), was involved in an incident on _____ (Date), in which I was injured due to the alleged acts or omissions of another person (the “**Incident**”).

One or more of the following scenarios applies to me: (i) I do not have public or private health insurance; (ii) I am unable to afford my health insurance co-pays, deductibles, co-insurance, or other related costs; (iii) my health insurance expressly excludes coverage for injuries caused by third parties (which is what happened in the Incident); *and/or* (iv) I have been denied coverage by my health insurance, in whole or in part, for medical treatment made necessary by the Incident.

The party who is at fault or otherwise responsible for the Incident and my resulting injuries (the “**At-Fault Person**”) has not agreed to pay for my medical care, or alternatively, will only agree to compensate me after I complete my medical treatment.

Considering the above circumstances, **Health Plus Wellness Center** (the “**Chiropractic - Health Care Provider**”) has agreed to provide me with the Chiropractic care I need to treat my injuries without requiring me to pay in full at the time of service. As a condition of the deferment, I hereby represent and covenant to the Chiropractic - Health Care Provider that I am seeking (or will timely seek) compensation from the At-Fault Person responsible for my injuries.

I understand that, despite the Chiropractic – Health Care Provider’s agreement to defer collection of the amounts billed for the healthcare services provided to me (collectively, the “**Amounts Due**”), I am personally and unconditionally responsible for all Amounts Due. I further understand and agree that if I elect not to seek compensation from the At-Fault Person responsible for my injuries, or if I am unsuccessful in doing so, I shall still owe the Amounts Due to the Chiropractic – Health Care Provider in full.

I acknowledge and agree that the Chiropractic – Health Care Provider’s offer to defer collection of the Amounts Due from me is purely discretionary. The Chiropractic – Health Care Provider may, at any time, elect to require payment in full for all amounts previously deferred, which shall be immediately due and payable by me. This agreement grants the Chiropractic – Health Care Provider a limited legal interest in the compensation from the At-Fault Person that I receive in connection with the Incident (a “**Recovery**”), if any, and guarantees payment out of that Recovery to the Chiropractic – Health Care Provider for the chiropractic care that I receive (or am due to receive). I hereby grant to the Chiropractic – Health Care Provider, and its successors and assigns, a security interest in, and a continuing lien on, all proceeds awarded or due from any Recovery that I receive (or am due to receive) in connection with the Incident. I further understand that the Chiropractic – Health Care Provider may file and record a lien to perfect its interest, and I expressly authorize it to do so.

I agree to provide reasonable updates to the Chiropractic – Health Care Provider about the status of my claim against the At-Fault Person and authorize and direct the attorney(s)/law firm(s) representing me (“**My Attorney**”), if and as applicable, to do the same. Upon receiving any Recovery amount, I agree to make immediate payment to the Chiropractic – Health Care Provider for all Amounts Due. I expressly authorize and direct My Attorney to make payment to the Chiropractic – Health Care Provider on my behalf from the Recovery received, in settlement of the Amounts Due. If a dispute arises between the Chiropractic – Health Care Provider and me, I expressly authorize and direct My Attorney to hold in trust all Recovery amounts until the final resolution of said dispute.

This agreement supersedes any prior agreement or arrangement by and between the parties hereto concerning the subject matter hereof. This agreement may be executed in counterparts, each of which shall be deemed to be an original. Each party agrees that this agreement may be electronically signed and that any electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, admissibility, and enforceability.

Patient Signature: _____ Signature Date: _____

Patient Date of Birth: _____ Phone Number: _____

Email: _____



Concussion Questionnaire

Patient Name: _____

Date of Injury: _____

Please use the following scale to rate your symptoms as listed below:

0 = Never Experienced

1 = Mild

2 = Moderate

3 = Severe

R = Resolved

Dizziness	0	1	2	3	R
Headaches	0	1	2	3	R
Hearing changes	0	1	2	3	R
Vision Changes	0	1	2	3	R
Balance Changes	0	1	2	3	R
Nausea and/or Vomiting	0	1	2	3	R
Light Sensitivity, bothered by bright light	0	1	2	3	R
Noise Sensitivity, bothered by loud noise	0	1	2	3	R
Sleep Disturbance	0	1	2	3	R
Fatigue, Tiring More Easily	0	1	2	3	R
Being Irritable, Easily Angered	0	1	2	3	R
Feeling Depressed or Tearful	0	1	2	3	R
Feeling Anxious or Tense	0	1	2	3	R
Poor Memory	0	1	2	3	R
Poor Concentration	0	1	2	3	R
Feeling Mentally Foggy	0	1	2	3	R