ProWellness Chiropractic

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 Break glass	Not strike object
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 paid started when _____

The pain is better when_____

The paid 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:

Very Satisfied
Satisfied
Dissatisfied
Very Dissatisfied

Highest Level of Education Completed:_____

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 lie n 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 suing 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: _____