



*Confidential Patient Health Record*

## PERSONAL INJURY PATIENT HISTORY

Please Check  all appropriate responses:

Today's Date: \_\_\_\_/\_\_\_\_/200\_\_

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  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: \_\_\_\_\_

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

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

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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?

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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

Eyes Light Sensitive

Fainting

Numbness in toes

Loss of memory

Irritability

Loss of balance

Cold feet

Chest pain

Anxious

Low Back Pain

Neck pain/Stiffness

Pain behind Eyes

Sleeping problems

Loss of smell

Fatigue

Depression

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

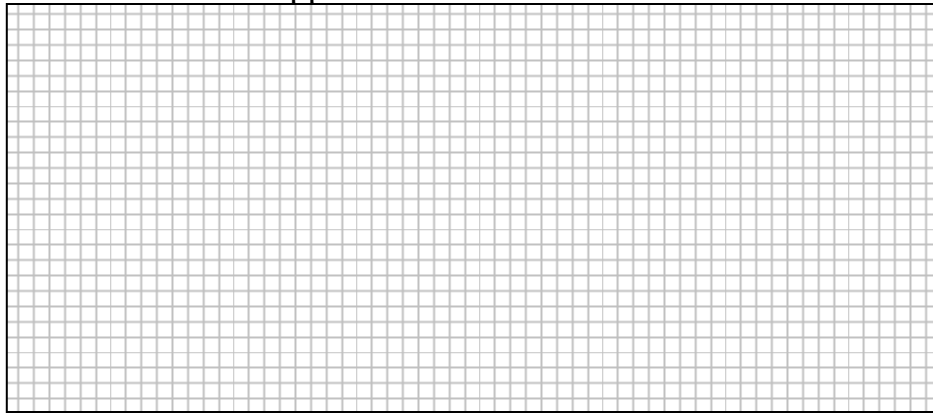
58. If yes, who? \_\_\_\_\_

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 Allergy 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**

**Genito-Urinary 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 Difficult 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

## Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. **Please Check**  one item in each section which most closely applies to you.

### SECTION 1 PAIN INTENSITY

- I can tolerate the pain I have without using painkillers.
- The pain is bad but I manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers give no relief from pain and I do not use them.

### SECTION 2 PERSONAL CARE (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

### SECTION 3 LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### SECTION 4 WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### SECTION 5 SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than one hour.
- Pain prevents me from sitting for more than 30 minutes.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### SECTION 6 STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it causes extra pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### SECTION 7 SLEEPING

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### SECTION 8 SEX LIFE

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### SECTION 9 SOCIAL LIFE

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

### SECTION 10 TRAVELING

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary trips under a half hour.
- Pain restricts me from traveling except to the doctor or hospital.

Current Chief Compliant(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

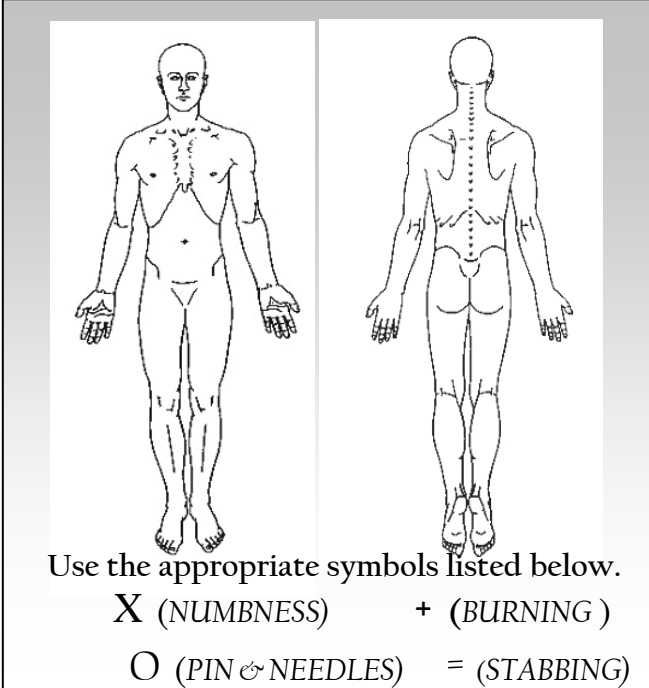
EMERGENCY

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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\_\_\_\_\_  
*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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\_\_\_\_\_  
*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*