



**NEW PATIENT
PAPERWORK FOR
PERSONAL INJURY
THAT IS NOT DUE TO A
MOTOR VEHICLE
ACCIDENT OR WORK
INJURY**

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Discuss your case with family
- Collect payment
- Do research
- Run our office
- Include you in care classes
- Inform you about other services
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to worker's compensation
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings

You have the right to:

- Request a copy of your health record
- Request confidential communications
- Request a list of whom we share your health information with
- Amend your protected health information
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

patient or guardian signature

date

PATIENT INFORMATION FORM

(Office use only)

1) New patient _____

Previous Patient (New Case) _____

Patient Code# _____

2) Date: ____/____/____ 3) Time ____ m 4) Claim# _____

5) First Name: _____ M.I. ____ Last Name: _____

6) Sex: 1) Male 2) Female

7) Birthdate ____/____/____ Age ____ Marital Status (S M W D) Spouse's Name _____

8) Social Security # ____/____/____ 9) Home Phone () ____ - ____ Cell Phone () ____ - ____

10) Address _____ City _____ State _____ Zip _____

11) Employer _____ 12) Job Title _____ Work Phone () ____ - ____

Driver's License No. _____ State: _____

Person Responsible for this account _____

Referred By _____

Primary Insurance: (Group ____ Work/Comp ____ Automobile ____ Other ____) 13) Policy # _____

Insurance Co. _____ 14) Group# _____

Address _____ City _____ State _____ Zip _____ Phone () ____ - ____

15) Primary name of Insured: _____ DOB: ____/____/____ Relationship to Patient _____ SS# _____

16) Employer _____ Employee # _____ Work Phone () ____ - ____

Work Address _____ City _____ State: _____ Zip _____

Secondary Insurance: (Group ____ Work/Comp ____ Automobile ____ Other ____) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____ State _____ Zip _____ Phone () ____ - ____

Primary name of Insured: _____ DOB: ____/____/____ Relationship to Patient _____ SS# _____

Employer _____ Employee # _____ Work Phone () ____ - ____

Work Address _____ City _____ State: _____ Zip _____

Other Insurance: (Group ____ Work/Comp ____ Automobile ____ Other ____) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____ State _____ Zip _____ Phone () ____ - ____

Primary name of Insured: _____ DOB: ____/____/____ Relationship to Patient _____ SS# _____

Employer _____ Employee # _____ Work Phone () ____ - ____

Work Address _____ City _____ State: _____ Zip _____

Are you or do you think you might be pregnant? 1) Yes 2) No

17) Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

I Understand and agree that health and accident insurances polices are an arrangement between an insurance carrier and me. I authorize payment for my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney's fees as may be required to effect collection.

Patient Signature _____ Date ____/____/____

PATIENT HEALTH HISTORY

Name: _____ Family Physician: _____

1) FAMILY HISTORY: (Circle as many as apply)

MOTHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

FATHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

SIBLINGS: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

2) SOCIAL HISTORY:

MARITAL STATUS: 1) Single 2) Married 3) Divorced 4) Widowed
NUMBER OF CHILDREN: (1) (2) (3) (4) (5) (6) (7) (8) (None)
DO YOU: 1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest
DO YOU SMOKE? 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (packs / day)
DO YOU DRINK COFFEE/TEA? 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (cups / day)
DO YOU DRINK ALCOHOL? 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (drinks / day)

3) MEDICAL HISTORY:

CHILDHOOD ILLNESSES: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes

LIST ANY SERIOUS CHILDHOOD ILLNESSES NOT RECORDED ABOVE.

Age: []

Age: []

Age: []

LIST ANY BIRTH DEFECTS:

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason and dates.

M/D/Y ____/____/____

M/D/Y ____/____/____

M/D/Y ____/____/____

ADULT ILLNESSES/INJURIES: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

M/D/Y ____/____/____

M/D/Y ____/____/____

M/D/Y ____/____/____

4) MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

A) _____ B) _____

C) _____ D) _____

MEDICATIONS IN WHICH YOU ARE ALLERGIC:

A) _____ B) _____

C) _____ D) _____

PERSONAL INJURY QUESTIONNAIRE

(Do not use this form for Motor Vehicle or Workmen's Compensation Cases)

Name: _____

If you are represented by an attorney for this injury, complete the following:

Attorney Name _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____

- 1) Date of accident: ____/____/____ 2) Time of accident: ____:____ (AM/PM)
3) Last day worked: ____/____/____ Date returned to: 4) Modified work. ____/____/____ 5) Regular work. ____/____/____
6) Are you working now? 1) Yes, part time 2) Yes, full time 3) No

7) Describe any pre-existing conditions, disabilities, or restrictions:

- A) _____ Onset: ____/____/____
Cause: 1) Auto Accident 2) Work Injury 3) Sports Injury 4) Injury at home 5) Other Injury 6) Illness 7) Congenital 8) Unknown Cause
- B) _____ Onset: ____/____/____
Cause: 1) Auto Accident 2) Work Injury 3) Sports Injury 4) Injury at home 5) Other Injury 6) Illness 7) Congenital 8) Unknown Cause
- C) _____ Onset: ____/____/____
Cause: 1) Auto Accident 2) Work Injury 3) Sports Injury 4) Injury at home 5) Other Injury 6) Illness 7) Congenital 8) Unknown Cause

8) In your own words, describe how the accident happened (please give details):

9) If a pedestrian hit by a vehicle, were you: 1) Standing 2) Walking in street 3) Jogging 4) Walking on sidewalk 5) Crossing street

10) Type of vehicle: 1) Auto 2) Light Truck 3) Truck 4) Van 5) Bus 6) Motorhome 7) Motorcycle 8) Motorscooter 9) Bicycle

11) Were you unconscious? 1) No 2) Not sure, how long 3) A few seconds 4) A few minutes 5) An hour 6) A few hours

12) After the accident, did you feel: (circle as many as apply)

- 1) Stunned 2) Frightened 3) Confused 4) Dazed 5) Dizzy 6) Shocked 7) Shaken 8) Nauseous

13) Did you receive medical aid at accident site? 1) Yes 2) No

14) Where did you go right after the accident?

- 1) Hospital 2) Emergency Treatment Center 3) Home 4) Family physician 5) To this office 6) Resumed activities 7) Work

15) How did you get there? 1) Ambulance 2) Drove myself 3) Someone drove me 4) Walked

16) Did your symptoms develop:

- 1) Immediately 2) Hours later 3) Next day 4) Over the first few days 5) During the first week

6) Over the next few weeks 7) Over the next few months

If you were treated by another Doctor or Therapist for this condition, answer questions 17-19

- 17A) Name: _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT*
- B) Tests Performed: 1) Exam 2) Xray 3) CAT scan 4) EMG 5) Thermography 6) MRI 7) EEG 8) Lab 9) Psychological
- C) Prescription received: 1) Pain Killers 2) Muscle Relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other
- D) Treatment frequency: 1) Daily 2) 1x a week 3) 2x a week 4) 3x a week 5) 4x a week
6) 1x a month 7) 2x a month 8) 3x a month
- E) Treatment duration: _____ (circle) 1) Days 2) Weeks 3) Months
- F) Date first appointment: ____/____/____ G) Date last appointment: ____/____/____
- H) Did Treatment Help? 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

*C.A.=Acupuncturist, D.C.=Chiropractor, D.D.S.=Dentist, D.O.=Osteopath, D.P.M.=Podiatrist, M.D.=Physician, O.D.=Optometrist, P.T.=Physical Therapist

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

PATIENT COMPLAINTS

NAME: _____

A) DATE: ____/____/____

B) GENERAL:		Frequency Const/Intermit		Intensity Mild/Moderate/Severe			Pain Type Sharp/Dull	
Anxiety		1	2	1	2	3		
Cannot concentrate		1	2	1	2	3		
Nervousness		1	2	1	2	3		
Irritability		1	2	1	2	3		
Fatigue		1	2	1	2	3		
Depression		1	2	1	2	3		
Memory loss		1	2	1	2	3		
Loss of sleep		1	2	1	2	3		
Tension		1	2	1	2	3		
Fainting spells		1	2	1	2	3		
Dizzy spells		1	2	1	2	3		
PMS		1	2	1	2	3		

C) HEAD:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Headaches		1	2	1	2	3	1	2
Jaw pain		1	2	1	2	3	1	2
Jaw tension		1	2	1	2	3		
Pain in ears	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Ringing in ears		1	2	1	2	3		
Ear discharge	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Hearing loss	Lt.			1	2	3		
	Rt.			1	2	3		
Eye pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Decreased acuity				1	2	3		
Light sensitivity				1	2	3		
Floating lights				1	2	3		
Nose bleeds				1	2	3		
Nasal obstruction				1	2	3		

D) NECK/THROAT:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Neck pain	Lt.	1	2	1	2	3	1	2
	Diffuse	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	1)Shldr 2)Arm 3)Elbw 4)Wrist 5)Fingers						
	Rt.	1)Shldr 2)Arm 3)Elbw 4)Wrist 5)Fingers						
Stiffness		1	2	1	2	3		
Grinding sounds		1	2	1	2	3		
Popping sounds		1	2	1	2	3		
Hoarseness		1	2	1	2	3		

E) SHOULDERS:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain with motion	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain at rest	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Muscle spasm	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Limited motion	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

F) ARMS:		Frequency Const/Intermit		Intensity Mild/Moderate/Severe			Pain Type Sharp/Dull	
UPPER ARM pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pins & Needles (upper arm)	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Numbness (upper arm)	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
ELBOW pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
FOREARM pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pins & Needles (forearm)	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Numbness (forearm)	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

G) HANDS:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Wrist pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Hand pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pins & Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Numbness - hand	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Thumb pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Index finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Middle finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Ring finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Little finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Numbness - frngr	Lt.	1)Index 2)Middle 3)Ring 4)Little 5)Thumb						
	Rt.	1)Index 2)Middle 3)Ring 4)Little 5)Thumb						
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

H) MIDBACK:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	MIDLINE	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Muscle spasm	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

I) LOWBACK:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	MIDLINE	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Stiffness		1	2	1	2	3		
Muscle spasm	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pain radiates to	Lt.	1)Buttocks 2)Hip 3)Side of Leg 4)Back of Leg						
	Rt.	1)Buttocks 2)Hip 3)Side of Leg 4)Back of Leg						

J) PELVIS:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull	O) CHEST:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Hip joint pain	Lt.	1 2	1 2 3	1 2	Deep chest pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2	Pain around ribs	Rt.	1 2	1 2 3	1 2
Sacroiliac pain	Lt.	1 2	1 2 3	1 2					
	Rt.	1 2	1 2 3	1 2	Pain with exertion		1 2	1 2 3	1 2
Buttock pain	Lt.	1 2	1 2 3	1 2	Shortness of breath		1 2	1 2 3	
	Rt.	1 2	1 2 3	1 2	Difficult breathing		1 2	1 2 3	
Groin pain	Lt.	1 2	1 2 3	1 2	Irregular heartbeat		1 2	1 2 3	
	Rt.	1 2	1 2 3	1 2	Rapid heart beat		1 2	1 2 3	
Tail bone pain	Lt.	1 2	1 2 3	1 2	Night sweats		1 2	1 2 3	
	Rt.	1 2	1 2 3	1 2	Chronic cough		1 2	1 2 3	
K) THIGH:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull	P) DIGESTIVE TRACT:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain	Lt.	1 2	1 2 3	1 2	Stomach pain		1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2	Indigestion		1 2	1 2 3	
Pain radiates to	Lt.	1)Knee___ 2)Calf___ 3)Ankle___			Nausea		1 2	1 2 3	
	Rt.	1)Knee___ 2)Calf___ 3)Ankle___			Gas		1 2	1 2 3	
Numbness	Lt.	1 2	1 2 3		Clay colored stool		1 2	1 2 3	
Pins and Needles	Lt.	1 2	1 2 3		Black tarry stool		1 2	1 2 3	
	Rt.	1 2	1 2 3		Hemorrhoids		1 2	1 2 3	
Knee pain	Lt.	1 2	1 2 3	1 2	Bleeding from rectum		1 2	1 2 3	
	Rt.	1 2	1 2 3	1 2	Abnormal weight loss		1 2	1 2 3	
Swollen knee	Lt.	1 2	1 2 3		Diarrhea		1 2	1 2 3	
	Rt.	1 2	1 2 3		Constipation		1 2	1 2 3	
Muscle weakness	Lt.	1 2	1 2 3		Q) URINARY TRACT:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
	Rt.	1 2	1 2 3		Painful urination		1 2	1 2 3	1 2
L) CALVES		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull	Frequent urination		1 2	1 2 3	
Calf Pain	Lt.	1 2	1 2 3	1 2	Unable to urinate		1 2	1 2 3	
	Rt.	1 2	1 2 3	1 2	Leakage of urine		1 2	1 2 3	
Pain radiates to	Lt.	1)Ankle___ 2)Foot___ 3)Toes___			Blood in urine		1 2	1 2 3	
	Rt.	1)Ankle___ 2)Foot___ 3)Toes___			Bedwetting		1 2	1 2 3	
Numbness	Lt.	1 2	1 2 3		R) WOMEN ONLY:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
	Rt.	1 2	1 2 3		Painful menstruation		1 2	1 2 3	1 2
Pins and Needles	Lt.	1 2	1 2 3		Excess menstruation		1 2	1 2 3	
	Rt.	1 2	1 2 3		Missed periods		1 2	1 2 3	
Cramps	Lt.	1 2	1 2 3		S) SUMMARY:				
	Rt.	1 2	1 2 3		You have identified general complaints and complaints in different parts of your body. Enter the letter (B thru R) to tell us where:				
Muscle weakness	Lt.	1 2	1 2 3		1) Is your most serious complaint. _____				
	Rt.	1 2	1 2 3		2) Is your next most serious complaint. _____				
M) ANKLES:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull	3) Approximate date of onset (if known): ____/____/____				
Pain	Lt.	1 2	1 2 3	1 2	4) Onset was: 1) Sudden 2) Gradual				
	Rt.	1 2	1 2 3	1 2	5) Are the complaints? (circle one)				
Swelling	Lt.	1 2	1 2 3		1) Improving 2) Getting worse				
	Rt.	1 2	1 2 3		3) About the same 4) Intermittent (Comes & Goes)				
N) FEET:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull	6) When are the complaints most noticeable?				
Pain	Lt.	1 2	1 2 3	1 2	1) Morning 2) Afternoon 3) Evening 4) Night				
	Rt.	1 2	1 2 3	1 2	7) What aggravates the complaint(s)?				
Numbness	Lt.	1 2	1 2 3		1) Standing 2) Walking 3) Sitting 4) Bending				
	Rt.	1 2	1 2 3		5) Lying 6) Lifting 7) Twisting 8) Coughing				
Pin and Needles	Lt.	1 2	1 2 3		8) What relieves the complaint(s)?				
	Rt.	1 2	1 2 3		1) Rest 2) Sitting 3) Lying 4) Bending				
Swelling	Lt.	1 2	1 2 3		5) Stretching 6) Exercise 7) Lying knees bent				
	Rt.	1 2	1 2 3						
Cramps	Lt.	1 2	1 2 3						
	Rt.	1 2	1 2 3						
Big toe pain	Lt.	1 2	1 2 3	1 2					
	Rt.	1 2	1 2 3	1 2					
2nd toe pain	Lt.	1 2	1 2 3	1 2					
	Rt.	1 2	1 2 3	1 2					
Mid toe pain	Lt.	1 2	1 2 3	1 2					
	Rt.	1 2	1 2 3	1 2					
4th toe pain	Lt.	1 2	1 2 3	1 2					
	Rt.	1 2	1 2 3	1 2					
Small toe pain	Lt.	1 2	1 2 3	1 2					
	Rt.	1 2	1 2 3	1 2					

