# APPLICATION FOR PERSONAL INJURY TREATMENT
# CONFIDENTIAL PATIENT INFORMATION

## PATIENT DATA

NAME _____ PHONE (____)_____ WORK PHONE (____)_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____ M / F MARITAL STATUS_____ NUMBER OF CHILDREN _____

**DRIVER LICENSE #** _____ **EMAIL ADDRESS** _____ **SOCIAL SECURITY#** _____

OCCUPATION _____ EMPLOYER _____

SPOUSE/RELATIVE NAME _____ RELATIONSHIP_____PHONE # (____)_____

## ACCIDENTAL INJURY REPORT

**DESCRIPTION OF ACCIDENT:** DATE OF ACCIDENT_____HOUR OF ACCIDENT_____AM/PM __

TYPE OF ACCIDENT ☐ AUTO ACCIDENT ☐ MOTOCYCLE / BIKE ☐ PEDESTRIAN ☐ SLIP AND FALL ☐ OTHER_____

NUMBER OF DAYS MISSED WORK DUE TO ACCIDENT_____ TYPE OF WORK _____

YOUR VEHICLE MAKE/MODEL/ YEAR?_____OTHER VEHICLE ?_____ SEAT BELT ON? ☐ YES ☐ NO

WERE YOU A ☐ DRIVER ☐ FRONT PASSENGER ☐ LEFT REAR PASSENGER ☐ RIGHT REAR PASSENGER ☐ OTHER _____

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? ☐ YES ☐ NO, MPH?_____ ☐ STOPPED AT INTERSECTION ☐ STOPPED IN TRAFFICE

☐ STOPPED AT A LIGHT ☐MAKING A RIGHT TURN ☐MAKING A LEFT TURN ☐PROCEEDING ALONG ☐SLOWING DOWN

☐OTHER _____

DID **YOUR VEHICLE** HIT OTHER VEHICLE/S ☐ YES ☐ NO, WHERE? ☐HEAD ON ☐LEFT/RIGHT FRONT ☐LEFT/RIGHT REAR ☐REAR-END ☐OTHER _____ ____

DID OTHER VEHICLE/S HIT YOUR VEHICLE ☐ YES ☐ NO, WHERE? ☐HEAD ON ☐LEFT/RIGHT FRONT ☐LEFT/RIGHT REAR ☐REAR-END ☐OTHER _____

WHAT IS THE POSITION OF THE HEADREST? ☐ EVEN W/TOP OF HEAD ☐ EVEN W/BOTTOM OF HEAD ☐ MIDDLE OF NECK ☐OTHER _____

WHAT WAS THE DIRECTION OF YOUR HEAD AT THE TIME OF THE IMPACT?☐ FACING STRAIGHT FORWARD ☐TURNED TO THE RIGHT ☐ TURNED TO THE LEFT

VISIBILITY AT TIME OF ACCIDENT ☐ POOR ☐ FAIR ☐ GOOD - ROAD CONDITIONS AT TIME OF ACCIDENT ☐ ICY ☐ WET ☐ SANDY ☐ DARK ☐ CLEAN AND DRY

DID YOU SEE ACCIDENT COMING? ☐ YES ☐NO - BRACE FOR THE IMPACT? ☐YES ☐NO – AIR BAG DEPLOYED? ☐ YES ☐ NO – _____

**DURING THE ACCIDENT:** DID YOUR BODY STRIKE THE INSIDE OF YOUR CAR ☐ YES ☐ NO. IF YES, DESCRIBE_____

DID YOU LOSE CONSCIOUSNESS ? ☐ YES ☐ NO HOW LONG?_____ ☐ IN SHOCK/NERVOUS ☐ DAZED ☐ CRYING

YOUR VEHICLE'S ESTIMATED DAMAGE?_____ MILD/MODERATE/SEVERE/TOTALED – OTHER VEHICLE? ☐ MILD ☐ MODERATE ☐ TOTALED

DID POLICE SHOW UP AT THE SCENE? ☐ YES ☐NO POLICE REPORT ? ☐ YES ☐ NO – ANY ARREST FOR DUI / HIT AND RUN? ☐YES ☐NO

**AFTER THE ACCIDENT:** WHERE DID YOU GO AFTER THE ACCIDENT? ☐HOME ☐WORK ☐HOSPITAL/ EMERGENCY _____

HOW DID YOU GET THERE? ☐DROVE SELF ☐SOMEBODY ELSE ☐AMBULANCE ___ HOW LONG? _____HRS – X-RAY/CT SCAN DONE? ☐ YES☐ NO

PRESCRIBED MEDICATIONS? _____ FOLLOW-UP INSRUCTIONS_____

☐ OTHER DOCTORS SEEN FOR THIS ACCIDENT INJURY?_____ ANY TREATMENT? ☐ YES ☐ NO

☐ PAIN MEDICATIONS _____ ☐ INJECTION ☐ PHYSICAL THERAPY ☐ CHIROPRACTIC ☐ ACCUPUNCTURE ☐ SURGERY_____

## PRESENT COMPLAINT

| | | | |
|---|---|---|---|
| ☐ HEADACHE | ☐ NECK PAIN/ STIFFNESS | ☐ LT / RT SHOULDER PAIN | OTHERS_____ |
| ☐ DIZZINESS | ☐ SHOULDER BLADE PAIN | ☐ LT / RT ARM PAIN | |
| ☐ NAUSEA | ☐ UPPER BACK PAIN | ☐ LT / RT ELBOW OR HAND PAIN | _____ |
| ☐ NERVOUSNESS | ☐ MID BACK PAIN | ☐ LT / RT HIP OR LEG PAIN | |
| ☐ RINGING IN EARS | ☐ LOW BACK PAIN | ☐ LT / RT KNEE OR ANKLE PAIN | _____ |
| ☐ SHORTNESS OF BREATH | ☐ RIBS PAIN | ☐ LT / RT FOOT PAIN | |

☐ CHEST PAIN ☐ NUMBNESS TO HANDS OR FEET ☐ BRUISES_____ ☐ SLEEPING PROBLEM ☐ DRIVING PHOBIA

**HAVE YOU HAVE SIMILAR ACCIDENTS OR INJURIES BEFORE?** ☐ YES ☐ NO ☐ SIMILAR COMPLAINS

## MEDICAL HISTORY

| | | | | |
|---|---|---|---|---|
| ☐ POLIO | ☐ DIABETES | ☐ REUMATISM | ☐ SCARLET FEVER | ☐ DIGESTIVE DISODERS |
| ☐ ANEMIA | ☐ HEPATITIS | ☐ CONCUSSION | ☐ HEART TROUBLE | ☐ HIGH BLOOD PRESSURE |
| ☐ ASTHMA | ☐ ARTHRITIS | ☐ CONVULSIONS | ☐ GERMAN MEASLES | ☐ MUSCULAR DYSTROPHY |
| ☐ CANCER | ☐ DIZZINESS | ☐ NERVOUSNESS | ☐ RHEUMATIC FEVER | ☐ HEADACHES |
| ☐ NEURITIS | ☐ NUMBNESS | ☐ TUBERCULOSIS | ☐ VENEREAL DISEASE | ☐ CARPAL TUNNEL |
| ☐ EPILEPSY | ☐ BACKACHES | ☐ SINUS TROUBLE | ☐ MULTIPLE SCLEROSIS | ☐ OTHER_____ |

## PREVIOUS CARE

SURGERIES ☐ YES ☐ NO WHERE?_____ WHEN? _____STATUS_____

TREATED BY A PHYSICIAN FOR ANY CONDITION IN THE LAST 12 MONTHS? ☐ YES ☐ NO WHAT KIND? _____

DESCRIBE CONDITION_____ DATE OF LAST PHYSICAL EXAM _____

ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD _____

## PATIENT'S AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 nay amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE_____ DATE _____

GUARDIAN'S SIGNATURE_____ DATE _____