Welcome

chiropractic care

PATIENT INFORMATION

Date _____

~~SS/HIC/Patient ID #~~ _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

~~ASSIGNMENT AND RELEASE~~

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

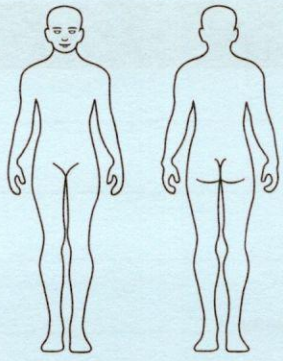
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____

☐ Alcohol Drinks/Week _____

☐ Coffee/Caffeine Drinks Cups/Day _____

☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

_____

Protecting Your Confidential Health Information is Important to Us

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s): _____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Brodheadsville Chiropractic
134 Pilgrim Way • Brodheadsville, PA 18322 • (570) 992-7626

Brodheadsville Chiropractic
Robert J. Van Metter, D.C.
P.O. Box 447, 134 Pilgrim Way
Brodheadsville, PA 18322
Phone 570-992-7626 · Fax 570-992-8759

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal.

Chiropractic has only one unique goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation to restore more optimum body function. The chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration or nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate healing ability. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Please print your name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

Patient ID #: _____

Brodheadsville Chiropractic
Robert J. Van Metter D.C.

Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Brodheadsville Chiropractic

Notice of Privacy Practices Acknowledgement

I acknowledge that Brodheadsville Chiropractic provided me with a copy of its Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act of 1996.

I authorize Brodheadsville Chiropractic and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them should this information change.

Home Telephone	Yes	No	Number:
Answering Machine	Yes	No	
Work Telephone	Yes	No	Number:
Cell Phone/Texting	Yes	No	Number:
Voicemail	Yes	No	
Fax to other physicians	Yes	No	

Please list names, relationship and number of family members and/or friends you wish us to release medical information pertaining to your healthcare.

Name	Relationship	Telephone Number

[ ] I DO NOT WISH ANY INFORMATION PERTAINING TO MY HEALTHCARE TO BE RELEASED TO FAMILY AND/OR FRIENDS.

Patient Signature: _____

Print Name: _____

Date: _____

WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

WRITE LEGIBLY

Name _____ Date _____ File # _____

30 HISTORY OF OCCURRENCE

10 Date of Accident:_____ Time:_____ ☐ AM ☐ PM Driver of Car: _____

Where were you seated? ☐ Driver's seat ☐ Front right passenger ☐ Front middle passenger

☐ Rear right passenger ☐ Rear middle passenger ☐ Rear left passenger

Who owns the car?_____ Year and model of car: _____

15 What was the damage done to the car you were in? ☐ Mild ☐ Moderate ☐ Severe ☐ Total ☐ Unknown

Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Snow/Icy ☐ Wet ☐ Clear ☐ Dark

Type of accident: ☐ Was hit in the ☐ Hit another car in the ☐ Rear ☐ Right side ☐ Left side ☐ Front

☐ Non-collision: (Describe) _____

40 IMPACT/SEAT BELT/HEADREST/SPEED

10 Describe in your own words what happened to you upon impact: _____

Were you aware the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No

Were you wearing a seat belt/shoulder harness? ☐ Yes ☐ No

20 Did the car you were in have a headrest? ☐ No

30 If yes, what was the position of the headrest compared to your head before the accident?

☐ Top of headrest even with **bottom** of the head ☐ Top of headrest even with **top** of the head

☐ Top of headrest even with **middle** of the neck

35 Was the car equipped with an airbag where you were seated? ☐ No

36 If yes did the airbag inflate? ☐ Yes ☐ No

37 Were you injured by the inflated airbag? ☐ No

38 If yes, what were the injuries? _____

40 Was your car braking? ☐ Yes ☐ No

50 Was you car moving at the time of accident? ☐ No

60 If yes, how fast would you estimate you were going? _____MPH (estimate)

70 How fast was the other car traveling? _____ MPH (estimate) ☐ Don't know

50 HEAD/BODY POSITION/ABLE TO MOVE BODY

10 Head/Body position at time of impact: ☐ Head turned: ☐ Right ☐ Left ☐ Head looking back

☐ Head straight forward ☐ Body straight in the sitting position Body rotated: ☐ Right ☐ Left

20 At the time of accident, recall what parts of your **head** or **body** hit what parts on the inside of your car: _____

_____

30 As a result of the accident you were: ☐ Rendered unconscious ☐ Dazed, circumstances vague

☐ Shaken up but could think clearly and function

40 Could you move all parts of your body? ☐ Yes

50 If no, what body parts could you not move and why? _____

60 Were you able to get out of the car and walk unaided? ☐ Yes

70 If no, why couldn't you get out of the car and walk unaided? _____

80 Did you receive any medical assistance at the scene of the accident? ☐ Yes ☐ No

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60 SYMPTOMS FROM ACCIDENT

10 Did you get any bleeding cuts or bruises? ☐ No

20 If yes, what **bleeding cuts** did you get from this accident? _____

If yes, what **bruises** did you get from this accident? _____

30 Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: _____

40 Later that ☐ Day ☐ Night: _____

50 Over the next days: _____

60 Check symptoms apparent **since** the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numb toes	☐ Chest pain
☐ Midback pain	☐ Ringing in ear	☐ Tension	☐ Numb fingers	☐ Nervousness
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Eyes sensitive to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxious
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	

70 WORK STATUS HISTORY

10 Employer: _____ Occupation: _____

20 Have you missed time from work? ☐ No

30-40 If yes: Full time off work: _____

50 If yes: Part time off work: _____

60 ☐ Been unable to work since the accident.

80 FIRST DOCTOR/HOSPITAL/CLINIC SEEN

10 Did you go to seek medical help immediately/soon after the accident? ☐ No

15 If yes, who first treated you? DOCTOR 1/HOSPITAL/CLINIC: _____ Date of 1st visit: _____

20 Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Were you given treatment? ☐ No

40 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment: _____

90 SECOND DOCTOR/CLINIC SEEN

10 DOCTOR 2/CLINIC: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Were you given treatment? ☐ No

30 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

100 THIRD DOCTOR/CLINIC SEEN

10 DOCTOR 3/CLINIC: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Were you given treatment? ☐ No

30 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

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110 PRIOR SIMILAR SYMPTOMS

10 Did you have any physical complaints **just before the accident?** ☐ No

20 If yes what physical symptoms did you have **just before the accident?** _____

_____

30 PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? ☐ No

40 If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.):

_____

120 ACTIVITIES OF DAILY LIVING

10 Do you notice any of your home activities that are different now than from before the accident? ☐ No

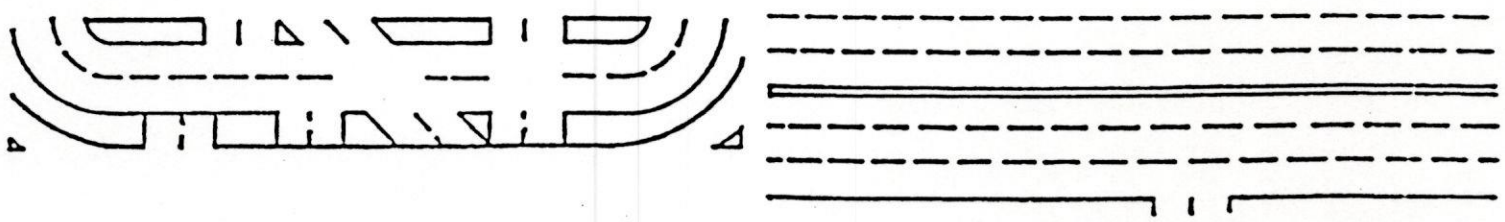
20 If yes, list them as:

30 Those activities that you are now unable to do are (be specific): _____

40 Those activities that are now painful to do are (be specific): _____

50 Those activities that are now difficult to do are (be specific): _____

INDICATE ON THIS DIAGRAM HOW THE ACCIDENT HAPPENED - (NOTE THE CAR YOU WERE IN AS CAR "A")



ATTORNEY ON CASE

Do you have an attorney on this case? ☐ No

If yes, who? Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Patient Signature: _____ Date: _____

AUTOMOBILE ACCIDENT — INSURANCE DATA

Patient's Insurance Company Information - (you)

Company Name: _____ Policy #: _____ Claim #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Adjuster's Name: _____ Phone: _____

Insured's Insurance Information - (Driver of car you were in--if not you)

Insured's name if other than you: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

Company Name: _____ Policy #: _____ Claim #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Other Driver's Insurance Information - (Other car's driver)

Other Driver's Name (if another car was involved): _____ Phone: _____

Adjuster's Name: _____ Phone: _____

Company Name: _____ Policy #: _____ Claim #: _____

Address: _____ City: _____ ST: _____ Zip: _____