ASSIGNMENT OF BENEFITS

PATIENT NAME: First _____ Middle _____ Last _____

PHONE NUMBER: Home: _____ Work: _____

HOME ADDRESS: _____ City _____ ZIP _____

AGE: _____ DOB: _____ SSN: _____ Status _____

EMAIL ADDRESS: _____

PATIENT EMPLOYER: _____ How long? _____ Occupation _____

SPOUSE'S EMPLOYER: _____ Spouse work phone _____

PATIENT AUTO INSURANCE COMPANY/PIP _____ POLICY# _____

CLAIM # _____ DATE OF ACCIDENT _____

INSURED'S NAME: _____ Relationship _____ SSN: _____

INSURED'S ADDRES: _____ DOB _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

ATTORNEY NAME _____ PHONE _____

HEALTH INSURANCE:

Insured's Name _____ Relationship to Patient _____

Insured's SSN _____ Group Number _____

Insurance Company Phone Number _____ Deductible _____ Met ___Y ___ N

DEDUCTIBLE _____ PIP 80% MEDICAL _____ TOTAL COVERAGE ___% VERIFIED _____

ADJUSTOR _____ PHONE _____ EXT _____ FAX _____

BILLING ADD _____ CITY _____ STATE _____ ZIP _____

Please describe what happened in the accident:

_____

_____

I was referred by

_____

"This is a direct assignment of my rights and benefits under any applicable policy of insurance. This includes an assignment of any cause of action that might accrue against any such insurance carrier for its failure to pay insurance proceeds."

_____ _____ _____

Signature of Patient (or Responsible Party) Date Signature of other responsible party

_____ _____

Witness Date

INITIAL VISIT
HISTORY QUESTIONAIRE

Today's Date _____ Date of Injury _____

Last Name _____ Name _____ Date of Birth _____

Referring Physician
Name: _____
Address: _____
_____
Phone: _____

Primary Care Physician
Name: _____
Address: _____
_____
Phone: _____

Reason for Visit:

Auto Injury____ Slip and fall____ Injury in your home ____ Injury at work_____
Other _____

Insurance coverage?____ PIP ____ Health Insurance ____ Self Pay

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If Automobile Accident, please complete the following:

___ Driver ____ Passenger (front/rear) ___ Pedestrian ____ Other

Location of accident _____

Please check as appropriate:

☐ I was stopped and someone rear-ended my car
☐ My car was pushed into the car in front of me
☐ I was hit by another car while moving through an intersection
☐ Another car hit my car head-on
☐ My car was sideswiped by another car going in the same direction
☐ The car I was in spun around or rolled over as a result of this accident
☐ The driver of the car I was in lost control and hit another car

☐ The driver of the car Iwas in lost control, ran off the road, and hit an objectI
☐ I was thrown from the car
☐ I was a pedestrian or a bicycle rider and was struck by a car
☐ Other _____

Area(s) of the body affected or injured _____
_____

Were you wearing a seatbelt? Y / N
Did the airbag deploy? Y / N
Did you strike any object inside the car? Y / N If so, please describe: _____

_____

Did you go to the Emergency Room? Y / N
Were you admitted to the hospital? Y / N

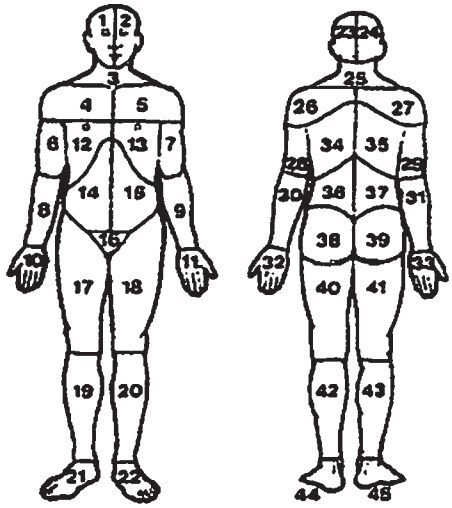
Describe any treatments received while in the emergency room or hospital: _____

_____

Have you received any other medical services prior to your first visit here? Y / N

INJURY AND HEALTH QUESTIONNAIRE

Please shade-in the areas of your body injured:



Pain level (no pain = 0; worst pain = 10):

Head ____ Neck____ Mid-back____Low-back____ Arm ____ Leg ____

How bad is your pain now? _____
Pain level with medications:_____ Average pain over last 24 hours: _____

Pain Quality
Please describe what your pain feels like:

__Throbbing	__Shooting	____Sharp	__ Cramping
__Pulling	__Burning	____Aching	__ Tender
__Numb	__Spreading	____Deep	

Pain Pattern

__Continuous	____ Rhythmic	___ Steady
__Comes and goes	____ Momentary	___ Brief

What can make your pain worse?
__Sitting ____ Standing ____Walking ____Lying flat on back
Other: _____

What can make your pain better?
__Sitting ____ Standing ___ Walking ____Lying flat on back
Other: _____
Please List: _____

How many hours of sleep are normal for you?
Do you have difficulty sleeping because of pain? ___yes __ no

Please list the names of any other health care provider that have been involved in your care prior to your visit with us:

Physician's Name: _____ Name of the clinic: _____
Physician's Name: _____ Name of the clinic: _____
Physician's Name: _____ Name of the clinic: _____
Physician's Name: _____ Name of the clinic: _____

Have you had physical or occupational therapy for pain? ___yes ___no
If yes, were they helpful? ___yes ___no

Have you seen a chiropractor for pain relief? _____yes _____no
Was this helpful? ___yes ___no

PAIN MEDICATIONS

Please list all current medications including any nonprescription such as Tylenol, Bengay, etc.

Name	Dose	How many tablets daily	Any side effects

Please list any drug allergies

Name of medication	Reaction	Name of medication	Reaction

PAST MEDICAL HISTORY

Have you had any of the following problems: (circle all that apply)

Asthma	Bowel disorder	Cancer	Depression
Diabetes	Heart disease	High blood pressure	Kidney disease
Lung disease	Bronchitis	Mental Illness	Tuberculosis
Polio	Rheuznatism	Seizures	Stroke
Thyroid	Ulcers	Other:_____	Other:_____

PAST SURGICAL HISTORY

Date (MO/YR)	**Procedures**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Do you have a family history with any of the following: (circle all that apply)

Diabetes	Rheumatoid arthritis
Back problems	Cancer
Tuberculosis	Heart attacks
Hypertension	Other: _____

REVIEW OF SYSTEM

Do you have any of the following symptoms recently?

Constitutional:	____ fever	___tiredness	___weight loss	___ poor appetite
Cardiovascular:	____ chest pain	___shortness of breath		___ palpitation
Respiratory:	____ cough	___wheezing	___asthma	___ breathing difficulty
Gastrointestinal:	____ nausea	___vomitting	___abdominal pain	___ constipation
Genitourinary:	____ urine incontinence		___difficult to start urination	
	____ pain on urination		___bloody urine	___ impotence
Female reproduction:	____ pregnant	___abnormal menstrual period		___ abnormal bleeding
Neurological:	____ headache	___arm weakness	___leg weakness	___ gait unsteadiness

Vision: ___visual difficulty ___glaucoma __eye pain
ENT: ___ear infection ___ear pain
Skin: ___rash ___skin cancer __infection __hypersensitivity __color change
Immunology:___rhematoid arthritis __SLE
Psychological:__depression ___anxiety __panic attack __suicidal ideation

DIAGNOSTIC TEST

Please indicate which Diagnostic test you have had for your recent complaints?

_____ yes _____no	MRI	Date (mo - yr) _____
_____ yes _____no	CT Scan	Date (mo - yr) _____
_____ yes _____no	X-Ray	Date (mo - yr) _____
_____ yes _____no	EMG	Date (mo - yr) _____
_____ yes _____no	Bone Scan	Date (mo - yr) _____
_____ yes _____no	Myelogram	Date (mo - yr) _____
_____ yes _____no	EKG	Date (mo - yr) _____

SOCIAL HISTORY

I am ___Single ___Married ___Divorced ___Widowed ___Do not wish to answer
Smoke cigarettes? ___yes ___no if so, how many packs per day? _____
Drink alcohol? ___yes ___no. If so, how much? _____
Consume caffine? _____yes _____no. If so, how much? _____
Are you pregnant? _____yes ___no
Do you currently take birth control pills? ___yes ___no
Have you missed any work as a result of this injury? _____yes _____no
If so, how many days? _____ Are you still off from work? _____yes _____no
I am employed: _____Full Time _____Part Time
Do you enjoy your work: _____yes _____no
Occupation/Job Title: _____
Employer _____

Patient Signature: _____ Date: _____