

PATIENT INFORMATION FORM

(OFFICE USE ONLY)

PI ACUPUNCTURE CASH WC PT INSURANCE

Patient File # _____ Doctors Name # _____

First Name _____ M.I. _____ Last Name _____

Birth Date ____/____/____ Age ____ Marital Status (S M W D)Spouse _____

SEX ____ SSN ____/____/____ Driver' Lic. No. _____ State ____

Address _____ City _____

State ____ Zip _____ Home Phone () _____

Work Phone () _____ Cell Phone () _____

Email _____

Employer _____ Referred By _____

Primary Insurance Co. _____ Policy # _____

Secondary/ Other Insurance Co. _____

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from 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 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 fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

Patient Signature _____ Date ____/____/____

Automobile Accident Questionnaire

Name: _____

Date of Accident: _____ Time: _____:_____ AM/PM

Lawyer's Name: _____ Phone: _____

Your Car Insurance Co. _____ Policy# _____ Med pay? _____

Other Vehicle Car Ins. _____ Policy # _____ Phone: _____

Your Vehicle: 1) Auto 2) Light Truck 3) Truck 4) Motorcycle 5) SUV 6) Bus

Other Vehicle: 1) Auto 2) Light Truck 3) Truck 4) Motorcycle 5) SUV 6) Bus

Were You: 1) The driver 2) The Passenger 3) Right Rear 4) Left Rear

Were you wearing your seat belt? 1) Yes 2) No

Did the airbags deploy? 1) Yes 2) No

Where was your vehicle hit? 1) Front 2) Rear 3) Lt. Side 4) Rt. Side

Please describe the accident:

Please Circle the part of body that was injured: 1) Head 2) Neck 3) Shoulder 4) Arm
5) Elbow 6) Wrist 7) Hand 8) Upper Back 9) Lower Back 10) Knee 11) Ankle 12) Foot

Did your symptoms develop: 1) Immediately 2) A few hours later 3) Next Day
4) After a few days

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

Where did you go after the accident? 1) Hospital 2) Emergency Room 3) Home
4) Work 5) To this office 6) Resumed activities

Name of Hospital: _____

What treatment did you receive? _____

What is the estimated cost of damage to the vehicle you were in? _____

Are your current injuries interfering with your job performance?

Are your current injuries interfering with your lifestyle?

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

HISTORY FORM

1. **Chief Complaint:** _____

Complaint Began when and how? _____

Have you had this pain before? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

How frequent is complaint present, how long does it last? _____

Is your complaint getting better, getting worse, or unchanged since it began? _____

Is there any daily activity you have difficulty with or can no longer do? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:**

3. **Past Health History:**

A. **Previous illnesses you've had in your life:** _____

B. **Previous injuries or fractures:** _____

C. **Allergies** _____

D. **Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. **Surgeries:** _____

4. **Family Health History:**

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

5. **Social and Occupational History:**

A. **Job physical demands:** _____

B. **Recreational activities:** _____

C. **Sleeping position:** _____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):** _____

Doctors Signature _____ Date _____