

HOFFMAN CHIROPRACTIC ACUPUNCTURE & SPORTS REHABILITATION
PERSONAL INJURY / WORKMAN COMPENSATION CASE HISTORY
CONFIDENTIAL PATIENT INFORMATION

Date _____ Name: _____ Middle Initial _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Cell: _____ Work #: _____ Email: _____

SSN: _____ DOB: _____ Marital Status: M S D W Number of Children: _____

Employer: _____ Occupation: _____

Attorney Name: _____ Phone: _____

AUTO/TRUCK/OTHER TYPE OF ACCIDENT ONLY

Date of Accident: _____ Approx. speed of vehicle you were in: _____

Were you: Driver Passenger Front seat Back seat Wearing a seat belt? YES NO Number of passengers: _____

Were you struck from: Behind Front Left Side Right Side Were you knocked unconscious? YES NO

Were police notified: YES NO Were you taken to the hospital? YES NO Do you have a police report? YES NO

Your Auto Insurance Company: _____ Policy: _____

Phone: _____ Agent: _____ Have you contacted them: YES NO

WORKMAN'S COMPENSATION ACCIDENTS ONLY

Date of Accident: _____ Did you report the accident that day? YES NO

To whom was the report made? _____ Name of contact person _____

ALL PATIENTS ANSWER THE REST OF THE QUESTIONS

In your own words, please describe the accident: _____

Please describe how you felt:

DURING THE ACCIDENT: _____

IMMEDIATELY AFTER: _____

CURRENT: _____

Did you have any physical complaints BEFORE THE ACCIDENT? YES NO If yes, please describe: _____

Do you have any previous illnesses which relate to this case? _____

Have you been treated by another doctor since the accident? YES NO If YES, Name of Doctor _____

What type of treatment have you received? _____

Were XRAYs taken: YES NO Have you lost any time from work as a result of this accident: YES NO

PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing?

2. If this is a re-occurrence, when did you originally notice the problem? _____
 What initially caused it?

3. Has it changed recently? _____ Better _____ Worse _____ Same What types of treatment have you tried?

What makes it better? _____ Worse? _____

4. How frequent is the condition? _____ How long does it last? _____

5. Is this affecting your sleep? _____ Yes _____ No If yes, please describe:

6. Is this affecting your ability to perform your job or daily activities? _____ Yes _____ No If yes, please describe:

7. Are there any other symptoms that may be related to these concerns, which you have not listed?
 _____ Yes _____ No

If yes, please describe: _____

Please mark an "X" on the line to indicate the severity of your condition:

No symptoms

Does not interfere with activities

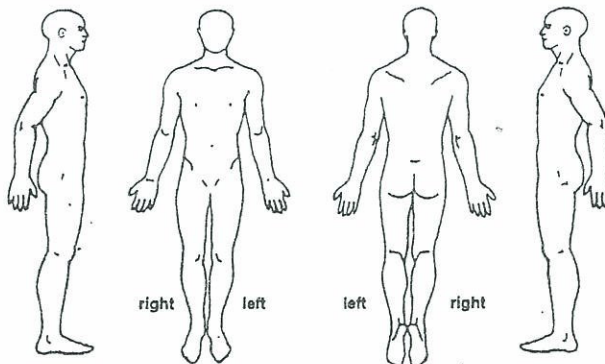
Extreme symptoms

Disabling

I _____ 10

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



Survey of Your Health History

Please circle all that apply. Indicate whether this is a current or old concern by providing an approximate date.

<p>1. General Fever Night sweats Nervousness Bleeding Diabetes Thyroid Headache Fainting Depression Memory loss Chills Fatigue Weight loss/gain Anemia Cancer Substance abuse Dizziness Seizures Phobias Waking in night Problems falling asleep Explain any surgeries or hospitalizations: _____ _____ Any broken bones, car accidents or other injuries? _____ _____</p>	<p>Chest pain High blood pressure Swelling Prior heart problem Pacemaker Stroke Other _____</p> <p>5. Musculoskeletal stiffness Pain Swelling Spinal curve Arthritis Weakness Twitching Tremors Numbness Other _____</p> <p>6. Skin Rashes Mole changes Itching Nail changes Redness Other _____</p> <p>7. EENT Blurry vision Double vision Eye pain Jaw pain Hearing loss Ringing in ears Ear infection Sinus problems Nosebleeds Throat problems Speech problems Glasses or contact? _____</p> <p>8. Genitourinary Frequent/painful urination Incontinence Blood in urine or stool Urinary infection Venereal infection Other _____</p> <p>9. Women Only Difficult periods Hot flashes Irregular cycles Breast pain Lump in breast</p>	<p>Difficulty becoming pregnant Complications of pregnancy Other _____</p> <p>Date last period ended _____ Date last gyne exam _____</p> <p>10. Men Only Testicular pain Prostate problems Difficult erection Low sperm count</p> <p>11. Exercise None 1-2 per week 3-4 per week 5-7 per week What type? _____</p> <p>12. Habits Smoke(____packs/day, years?__) Alcohol(____drinks per wk) Caffeine(____cups per day) Recreational drug use _____</p> <p>13. Family Are your parents living?____ If so, do you consider them to be in good health?____ Ages:Mother____Father____</p> <p>Circle any below that apply to your parents, siblings or children: Diabetes Stroke Hypertension Cancer Seizures Tremors Brain disorder Heart disease Lung disease Arthritis Scoliosis</p>
<p>2. Gastrointestinal Belching/gas Vomiting Bloody stools Hernia Constipation Diarrhea Abdominal pain Nausea Liver problems Other _____</p>		
<p>3. Respiratory Breathing problems Spitting phlegm/blood Allergies Asthma Shortness of breath Chronic cough Pneumonia Other _____</p>		
<p>4. Cardiovascular Irregular heartbeat Racing heart</p>		

Hoffman Chiropractic Clinic
 511 N. Convent
 Bourbonnais, IL 60914
 815-937-0446

Because of the nature of Personal Injury and Workman's Compensation regulations, it is extremely important to maintain your treatment schedule. If you miss your scheduled appointment & fail to reschedule that appointment later on that same day, there will be an "office visit" fee charged to your insurance carrier.

Please note that the bills for services will be submitted to your insurance company or responsible party and/or attorney. Please be aware that once your attorney has signed an Attorney's Lien form, indicating that our bill will be protected, then we will honor this agreement & allow for payment to be made upon settlement of your claim. However, should you decide to terminate your treatments, before you have been released by Dr. Hoffman, then your entire bill will become due and payable within 10 days following the date of your last visit.

LEGAL ASSIGMENT OF BENEFITS AND RELEASE OF MEDICAL & PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Hoffman Clinic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature _____ Date _____

HOFFMAN CHIROPRACTIC ACUPUNCTURE AND SPORTS REHABILITATION

511 N. Convent Bourbonnais, IL 60914 815-937-0446

www.drhoffmanchiropractic.com