

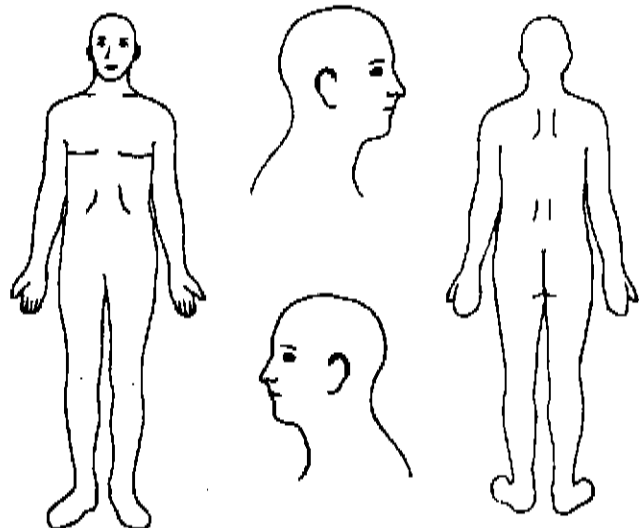
CONFIDENTIAL CLINICAL RECORD

GENERAL INFORMATION - PLEASE PRINT

PATIENT NAME _____ HOME ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____ HOW LONG? _____
 PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
 BIRTHDATE ____ / ____ / ____ SEX: M - F _____ MARITAL STATUS M - S - D - W _____ CHILDREN _____
 YOUR EMPLOYER _____ CITY _____ YEARS WITH FIRM _____
 OCCUPATION _____ SOCIAL SECURITY # ____ / ____ / ____
 DRIVERS LICENSE NO. _____ HOME PHONE _____ WORK PHONE _____
 CELL PHONE _____ EMAIL _____
 SPOUSE'S NAME _____ S.S. # ____ / ____ / ____ OCCUPATION _____
 SPOUSE'S EMPLOYER _____ CITY _____ HOW LONG? _____
 NEAREST RELATIVE NOT LIVING WITH YOU _____
 ADDRESS _____ CITY _____ PHONE _____
 PHYSICIAN _____ DATE OF LAST PHYSICAL _____
 DENTIST _____ DATE OF LAST VISIT _____
 DATE OF LAST CHIROPRACTIC ADJUSTMENT ____ / ____ / ____ SEEN BY DR. _____
 WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____
 ADDRESS IF DIFFERENT _____ PHONE _____
 WHO MAY WE CONTACT IN CASE OF EMERGENCY? _____
 PHONE _____ WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT

(Describe in your own words your problem and how it happened or started)

When was the very first time you were aware of this problem?

Have you ever had this problem or similar problem before? _____

If yes, explain: _____

Have you ever received any treatment for this condition? _____
 If yes, when, where and what were the results?

Is the problem better worse the same

What makes it better? _____

What makes it worse? _____

How has this problem affected your life:

List all surgery you have had and the dates

- A. Home _____
- B. Work _____
- C. Recreation _____
- D. Rest and Sleep _____

Have you ever been in an automobile accident? Never Past Yr. Past 5 Years Over 5 Yrs.

Describe any other accidents or falls you have ever had _____

Have you ever? Been stunned or unconscious Had broken bones Used a cane or crutch Been hospitalized What for _____

Had a nervous breakdown

Had any major illness Describe _____

DRUGS YOU NOW TAKE: Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers Insulin Birth Control Pills Other (please list) _____

Have you or any of your blood relatives had? High Blood Pressure Venereal Disease

Tuberculosis Heart Disease Diabetes Arthritis Epilepsy Cancer Polio

Habits: fill in number or check those that apply

No. hours sleep _____ Exercise routinely Do you smoke

How many cups or glasses _____ tea _____ coffee _____ soda _____ alcohol

Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

GENERAL SYMPTOMS

- 784.0 Headache
- 346.9 Migraine headache
- 780.8 Night Sweating
- 780.2 Fainting
- 780.4 Dizziness
- 780.3 Convulsions
- 780.52 Loss of sleep
- 780.7 Fatigue
- 799.2 Nervousness
- 783 Loss of weight
- 278.0 Obesity
- 995.3 Allergy
- 781 Tremors

RESPIRATORY

- 786.2 Chronic cough
- 786.50 Chest pain
- 786.09 Pain or difficulty breathing with exercise

GENITOURINARY SYMPTOMS

- 788.3 Frequent urination
- 788.1 Painful urination
- 592 Kidney infection/stones
- 601.9 Prostate trouble

CARDIO-VASCULAR

- 785 Rapid beating heart
- 427.89 Slow beating heart
- 401.9 High blood pressure
- 458.9 Low blood pressure
- 786.51 Pain over heart
- 719.07 Swelling of ankles
Right Left
- 436 Paralytic stroke

GASTROINTESTINAL SYMPTOMS

- 783 Poor appetite
- 994.2 Excessive hunger
- 787.3 Belching or gas
- 787 Nausea or Vomiting
- 536.8 Pain over stomach
- 564 Constipation
- 558.9 Diarrhea
- 789 Colon trouble
- 455.6 Hemorrhoids (Piles)
- 575.9 Gall bladder trouble
- 558.9 Colitis

E.E.N.T.

- 368.9 Failing vision
- 389.9 Deafness
- 388.70 Earache
- 388.30 Ear noises
- 784.7 Nose bleeds
- 462 Sore throat
- 493.9 Asthma
- 460 Frequent colds
- 240.9 Enlarged thyroid
- 686.9 Sinus problems

MUSCLE & JOINT SYMPTOMS

- 716.9 Arthritis
- 782 Numbness/pain in arms, hands, or legs, toes
- 719 Swollen joints
- 719.7 Difficulty in walking
- 722.10 Low back pain
- 722.2 Disc displacement
- 723.1 Pain in neck
- 723.5 Stiff neck
- 724.1 Pain between shoulders
- 724.79 Painful tailbone
- 728.85 Muscle spasms
- 729.4 Foot trouble
- 737 Faulty posture
- 737.3 Spinal curvature
- 781 Tremors
- _____ Shoulder pain
- _____ Knee pain
- _____ Elbow pain
- _____ Ankle pain

FOR WOMEN ONLY

- 611.72 Lumps in breast
- 623.5 Vaginal discharge
- 625.3 Painful menstrual periods
- 626.2 Excessive flow
- 626.4 Irregular cycle
- 627.2 Menopausal symptoms
- Date of last period ____ / ____ / ____
- Are you pregnant? _____
- Number of pregnancies _____
- Number of live births _____
- Birth Control method _____

SKIN

- 698.9 Itching
- 287.8 Bruises easily
- 701.1 Dryness
- 454.9 Varicose veins
- 782 Sensitive skin

Signature _____
Patient/Guardian

PERSONAL INJURY/WORKMEN'S COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

What was your position in car? Driver Passenger. If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike other vehicle? Yes No. Was your car struck by other vehicle? Yes No

Was the impact from the front? from the right side? from the left side? from the rear?

At the time of impact, were you looking straight ahead? looking right? looking left?

Were both hands on steering wheel? Yes No Was your foot on brake? Yes No Were you braced for impact? Yes No

Where in the car were you after the accident? _____

Were you wearing seat belts? Yes No Did you strike anything in vehicle at time of impact? Yes No

If yes, specify: Steering Wheel Dashboard Windshield Side Door Arm Rests

Side Window. Please state part of body: Chest Chin Knee Shoulder Hand Head

Immediately following the accident, how did you feel? _____

Were you unconscious? Yes No In a daze? Yes No Did you go to hospital? Yes No

If you went to hospital, when? At time of accident Yes No Next day Yes No

How did you get to hospital? Ambulance Yes No Private Transportation Yes No

Did the ambulance attendants place you in: Neck Collar Yes No Splints Yes No Brace Yes No

Name of Hospital: _____

Attended by Dr. _____ Were you x-rayed at hospital? Yes No

If so, what was the diagnosis? _____

Were you admitted to the hospital? Yes No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? Yes No See orthopedic doctor Yes No

Physical Therapy Yes No

Have you seen any other doctor as a result of this accident? Yes No

Doctor's name _____

Is your pain constant? Yes No Is the pain on and off? Yes No Sharp? Yes No Dull? Yes No

Other _____

Is your pain worse when arising from a chair? Yes No Is it made worse by straining? Yes No By coughing? Yes No

By sneezing? Yes No By straining when moving your bowels? Yes No

Do you have any numbness or tingling in your arms Yes No In your hands? Yes No In your fingers? Yes No

In your legs? Yes No In your feet? Yes No In your toes? Yes No

What is your most comfortable position? Sitting Yes No Lying on your right side Yes No On your left side Yes No

Lying on your back Yes No On your stomach Yes No Standing Yes No

Other _____ Is it difficult for you to move around in bed? Yes No

Does stretching and twisting worsen the pain? Yes No

Do any of the following relieve your pain? Heating Pad Hot Bath Shower Ice Pack

Does a brace (if you have tried one) help relieve the pain? Yes No

Does a change in heel height worsen the pain? Yes No Do you feel better moving around? Yes No Or resting? Yes No

Do you have a firm mattress? Yes No Do your knees ache or hurt? Yes No Do you have cramps in leg? Yes No

in arm? Yes No Have you had any change in your bowel habits? Yes No

Have you lost any time from work because of this accident? Yes No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

1. How much weight? Maximum Average
2. How far could you carry this weight? _____ For how long a period of time? _____
3. Was this lifting done at work? Yes No Or at home or elsewhere? Yes No
4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
2. Did you experience this pain, discomfort, or restriction of motion before your accident? Yes No
3. How far can you carry this weight how? _____ And for how long a period of time? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? Yes No
If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

- LIFT Very heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.
WORK Very heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort? Standing Walking Sitting

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

- Standing Walking Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

- Yes No

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work? Yes No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

- | | | | | |
|--------------|--------------|---------------|-----------------|------------|
| 1. Walking | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 2. Standing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 3. Sitting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 4. Bending | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 5. Stooping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 6. Lifting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 7. Pushing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 8. Pulling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 9. Climbing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 10. Reaching | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 11. Gripping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 12. Kneeling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 13. Balance | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 14. Fatigue | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |

Generally speaking, is your inability to perform these functions due to Pain Weakness Structural limitations Nerves?

Do you have normal sexual function? Yes No

Are you able to take care of your personal self, such as dressing, bathing, etc.? Yes No Or do you require assistance? Yes No

Do you feel your present condition is temporary? Yes No Or permanent? Yes No

Patient's Signature _____

Date: _____

IN THE EVENT OF AN AUTOMOBILE ACCIDENT THERE ARE MANY POSSIBILITIES FOR FILING ON INSURANCE. OUR OFFICE WILL STRIVE TO FILE AND COLLECT WHATEVER FUNDS MAY BE AVAILABLE TO YOU. WE FILE ALL PIP CLAIMS AND HEALTH INSURANCE CLAIMS FOR YOU AND WHEN THE PAYMENTS ARRIVE THEY ARE CREDITED TO YOUR ACCOUNT. IN THE EVENT THAT YOUR HEALTH AND PERSONAL INJURY PROTECTION EXCEEDS YOUR CHARGES THE EXCESS WILL BE REFUNDED TO THE PATIENT. IF YOUR ACCOUNT HAS BEEN CLEARED BEFORE LIABILITY PAYMENT HAS BEEN MADE THEN THIS OFFICE WILL RELEASE THE CLAIM AND THE PAYMENT WILL BE MADE DIRECTLY TO THE PATIENT. THIS OFFICE WILL ACCEPT ASSIGNMENT ON VERIFIED INSURANCE WHEN ALL FORMS HAVE BEEN SIGNED, BUT THE PATIENT IS RESPONSIBLE FOR ALL CHARGES THAT ARE NOT PAID BY THE INSURANCE COMPANY. IN THE EVENT THAT AN ATTORNEY HAS BEEN INVOLVED THE PATIENT MUST NOTIFY OUR OFFICE WITHIN 24 HOURS. IF AN ATTORNEY HAS CHANGED OR BEEN DISMISSED OR RELEASED THE CASE THEN PATIENT MUST NOTIFY OUR OFFICE WITHIN 24 HOURS OR THE BILL MAY BECOME DUE AND PAYABLE BY THE PATIENT IMMEDIATELY.

THE PATIENT MUST COOPERATE AND PROVIDE INFORMATION AS NEEDED. OUR OFFICE WILL DO THEIR VERY BEST TO COLLECT ALL FUNDS AS QUICKLY AS POSSIBLE. WE APPRECIATE OUR CHANCE TO SERVE YOU.

PERSONAL INJURY---AUTOMOBILE ACCIDENT

NAME _____ PHONE _____

DATE OF ACCIDENT _____ TIME _____ WHERE _____

PIP INSURANCE (PATIENT'S)

NAME OF INSURED _____ POLICY _____

INSURANCE COMPANY _____ PHONE _____

INSURANCE AGENT _____

EFFECTIVE DATE _____ CLAIM # _____

PIP INSURANCE (DRIVER'S)

NAME OF INSURED _____ POLICY _____

INSURANCE COMPANY _____ PHONE _____

INSURANCE AGENT _____

EFFECTIVE DATE _____ CLAIM # _____

PIP INSURANCE (OTHER AUTOMOBILE OWNED)

NAME OF INSURED _____ POLICY _____
INSURANCE COMPANY _____ PHONE _____
INSURANCE AGENT _____
EFFECTIVE DATE _____ CLAIM# _____

HEALTH INSURANCE-PRIMARY (PATIENT'S)

NAME INSURED _____ POLICY _____
HOW RELATED TO INSURED _____ GROUP _____
INSURANCE COMPANY _____ PHONE _____
ADDRESS _____
POLICY # _____ GROUP _____
TYPE OF POLICY: GROUP _____ PERSONAL _____
EMPLOYER _____

HEALTH INSURANCE-SECONDARY (SPOUSE'S)

NAME OF INSURED _____ POLICY _____
HOW RELATED TO INSURED _____ GROUP _____
INSURANCE COMPANY _____ PHONE _____
ADDRESS _____
POLICY# _____ GROUP# _____
EMPLOYER _____

LIABILITY INSURANCE--BODILY INJURY

NAME INSURED _____ POLICY _____

INSURANCE CO. _____ PHONE _____

INSURANCE AGENT _____

ADDRESS _____

ATTORNEY INFORMATION

LAW OFFICE OF _____ PHONE _____

ADDRESS _____