WELLNESS AROUND THE WORLD CHIROPRACTIC

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential History will be part of your permanent records. Thank You.

Name_____Date of Birth_____ Sex M / F

Address_____City _____ State_____ Zip_____

Soc. Sec #_____Home Phone_____Cellphone/Alt # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of Children/ages_____

Emergency Contact: Name:_____Phone #_____

Occupation:_____ Employer_____

Reason for Dr's Visit today?_____

Date of Accident _____ Date when symptoms first appeared _____
Cause of Injury ☐ Motor Vehicle Accident ☐ Fall ☐ Other

Have you had this or similar conditions in the past? _____

Does any body positions relieve the symptoms? _____

Does any body positions make it feel worse? _____

Is this Condition ☐ getting better, ☐ Unchanged, ☐ Getting Worse

List any Doctors or Therapist who have treated this condition:_____

List any surgical operations and years:_____

Name & Address of Primary Care Physician: _____

All Medications, dosage and frequency: _____

AUTO ACCIDENT or PERSONAL INJURY INFORMATION

Has a Lawyer been Retained? ☐ YES Name of Attorney _____
☐ NO (if no would you like one to contact you) _____

HEALTH/AUTO INSURANCE/WORKER'S COMPENSATION

Primary Insurance Company: _____ Address: _____
Phone # _____Policy # _____Group _____Type: ☐ Group ☐ Private
Secondary Insurance Company _____Address: _____
Phone # _____Policy # _____Group _____Type: ☐ Group ☐ Private
Complete if Insured is Different than Patient:
Insured's Name_____Insured's Date of Birth_____ Relationship to Patient_____
Insured's Employer_____
AUTOMOBILE ACCIDENT/WORKER'S COMPENSATION:
Insurance Company: _____ Address: _____
Adjuster's Name: _____Phone #:_____EXT: _____
Claim # _____ Policy #_____ Date of Injury_____

RELEASE AND ASSIGNMENT

I authorize the release of any information necessary to process my insurance claims. I hereby assign and request payment directly to my health care provider

Patient's Signature:_____ Date:_____
Parent/Guardian: _____ Date:_____

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WELLNESS AROUND THE WORLD CHIROPRACTIC

HEALTH HISTORY

Date _____ Sex ☐ Male ☐ Female Handedness: ☐ Right ☐ Left

Name: _____ Primary Care Physician _____

Last First MI

Age: _____ Height _____ Weight _____ Referring Physician _____

SYMPTOMS

(please check if you currently have or have had in the past)

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Faintin
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain,weaknees/numb
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Neck ☐ Feet
- ☐Hands ☐ Shoulder

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Ear Discharge
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

MEN only
- ☐ Breast Lump
- ☐ Erection difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap smear
- ☐ bleeding between periods
- ☐ Breast Lump
- ☐ extreme menstrual pain
- ☐ Hot Flashes
- ☐ Nipple discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of Last Menstrual period _____

Date of Last Pap Smear _____

Date of Mamogram ____

Are You Pregnant? ☐ Yes ☐ No

Number of Children _____

CONDITIONS

(please check conditions you have or have had in the past)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Sickle Cell Anemia
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Kidney Disease
- ☐ Liver Damage
- ☐ Measles
- ☐ Migrane Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING _____

LIST ALL ALLERGIES (i.e. Medicine, Shell Fish, Nuts, etc): _____

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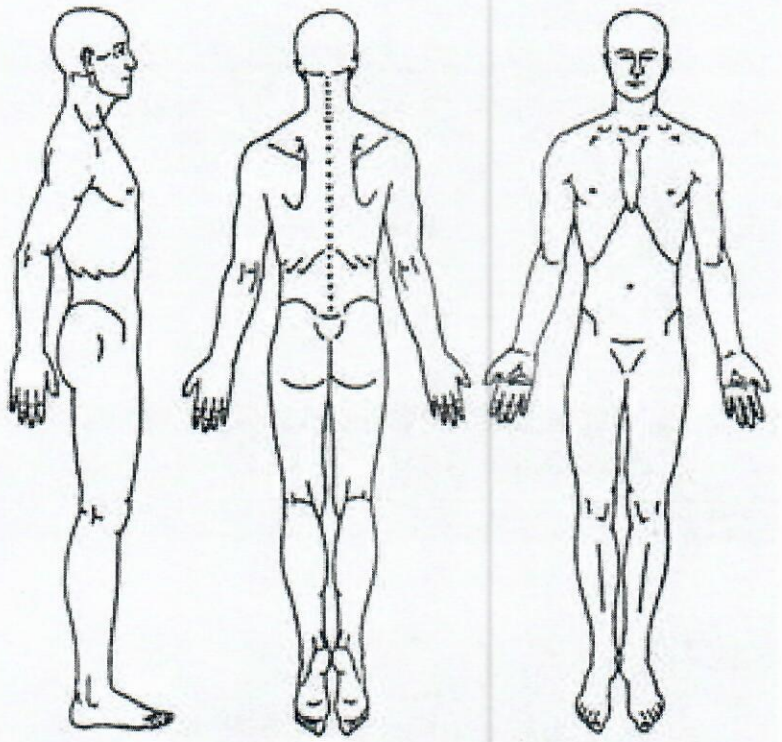
WELLNESS AROUND THE WORLD CHIROPRACTIC

PAIN QUESTIONNAIRE

PATIENT NAME_____ DATE_____
AGE_____ DATE OF BIRTH_____ OCCUPATION_____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN

A= Ache P= Pins and Needles B= Burning S = Stabbing N= Numbness O = Other



PLEASE RATE YOUR PAIN ON THE FOLLOWING SCALE (Please Circle)

0	NO PAIN
1	VERY MILD
2	DISCOMFORTING
3	TOLERABLE
4	DISTRESSING
5	VERY DISTRESSING
6	INTENSE
7	VERY INTENSE
8	UTTERLY HORRIBLE
9	EXCRUCIATING UNBEARABLE
10	UNIMAGINABLE/UNSPEAKABLE

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WELLNESS AROUND THE WORLD CHIROPRACTIC

AUTOMOBILE ACCIDENT DESCRIPTION

Please answer the questions below if you do not know the answer to any please do not answer.

1. VEHICLE TYPE

☐ Car ☐ SUV ☐Van
☐ Truck ☐ Commercial Vehicle
☐ Bus ☐Public transportation
Other _____

2. YOUR POSITION IN VEHICLE

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
☐ Other _____

3. WHAT WAS YOUR VEHICLE DOING

☐ Stopped in Traffic ☐ Stopped @ Light
☐ Intersection ☐ Right Turn ☐ Left Turn
☐ Slowing Down ☐ Accelerating ☐
☐ Other _____

4. Time/Speed/Damage

Time of Accident _____ am/pm
Your Speed _____
Other Driver's Speed _____

DAMAGE TO YOUR VEHICLE

☐ Mild ☐Moderate ☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

WHO HIT WHOM/WHAT?

☐ You Hit Other Vehicle
☐ Other Vehicle Hit You
☐ You Hit Object _____

6. Road Conditions

Road conditions time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dry ☐ Dark

POINT OF IMPACT

☐ HEAD ON ☐ Left Front ☐ Right Front
☐ REAR-END ☐ Left Rear ☐ Right Rear

7. Body Position, etc

Did you see the accident coming ☐Yes ☐ No
Were You braced for the accident? ☐ Yes ☐ No
Did you have your seat belt on? ☐ Yes ☐ No
Did you have shoulder strap? ☐ Yes ☐ No

Does Your Vehicle Have Head Rests? ☐ Yes ☐ No
Position of your headrest at the time of impact?
☐ Even Top of Head ☐ Even bottom of head ☐ Middle of Neck
What was the direction of your head at impact?
☐ Facing Forward ☐ Turned Right ☐ Turned Left

Did the Driver's Air Bags Deploy ☐ Yes ☐ No
Did Side Air Bags Deploy ☐ Yes ☐ No

Did Passenger Air Bags Deploy? ☐ Yes ☐ No

8. Additional Accident Information: _____

9. During the Accident

Did your body strike the inside of the vehicle ☐ Yes ☐ No
If yes, Describe _____
Did you Lose Consciousness? ☐ Yes ☐ No
If Yes, How Long _____
Damage to Their vehicle? ☐ Mild ☐Moderate ☐ Total Loss
Did the Police Show up at the scene? ☐ Yes ☐ No
Was accident report filed ☐ Yes ☐ No

10. After the Accident

Check off your symptoms following the accident:

☐ Headache ☐ Dizziness ☐ Mid Back Pain
☐ Neck Pain ☐ Nausea ☐ Low Back Pain
☐ Neck Stiffness ☐ Confusion ☐ Nervousness
☐ Depression ☐ Tension ☐ Anxious
☐ Lacerations, If so where _____
☐ Other _____

11. EMERGENCY ROOM

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ☐ Doctor
How did you get there?
☐ Drove self ☐ Ambulance ☐ Friend/Family
Were X-rays Taken? ☐ Yes ☐ No
Type of Lab Work _____
Medications Given ☐ Yes ☐ NO

_____

12. TREATMENT HISTORY

Fill in other doctor's seen prior to this visit:
1. _____ date of visit_____
2. _____ date of visit_____
Types of Treatment Received _____
Any other Tests (MRI, CAT SCAN) _____
Date of LAST VISIT _____

Attorney Name:_____ AUTO INSURANCE ADJUSTOR_____

AUTHORIZATION AND RELEASE

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WELLNESS AROUND THE WORLD CHIROPRACTIC

CONSENT FOR TREATMENT

I, the undersigned hereby authorize the Doctors of **WELLNESS AROUND THE WORLD CHIROPRACTIC** and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment when necessary.

I, also, certify that no guarantee or assurance has been made to the results that they may be obtained.

I understand and agree that accident insurance policies are an arrangement between and insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ Date _____ Witness _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date _____ Witness _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance company/Insurance Administer to pay by check, and for it to be mailed directly to **WELLNESS AROUND THE WORLD CHIROPRACTIC** the expense benefits allowable and otherwise payable to me under my current policy and other wise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ Date _____ Witness _____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient, am directing my Attorney, _____ to pay an outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Patient's Signature _____ Date _____ Witness _____

CONSENT FOR *TREATMENT OF A MINOR*

I hereby authorize the Doctors of **WELLNESS AROUND THE WORLD CHIROPRACTIC** and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____(indicate relationship to child) _____ (child's name).

Guardian's Signature _____ Date _____ Witness _____

X-RAYS/MEDICAL RECORDS RELEASE

I have requested the release of record of _____(patient's name) which are part of the records at **WELLNESS AROUND THE WORLD CHIROPRACTIC**. I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment, or opinion concerning any condition that may have had in the past, no have or may have in the future.

Please forward this information to PREMIERE REHAB CENTER 3286 Buckeye Rd Suite 102, Atlanta GA 30341

Patient's Signature _____ Date _____ Witness _____

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