PERSONAL INJURY PATIENT CASE HISTORY

Date: ___/___/______

PATIENT INFORMATION

Name: ____ Date of Birth ___/___/______ Age: _____

Last First Middle Initial

Sex: ____ Number of Children: _____ Social Security Number: _____ - ____ - ______

Marital Status: M S W D Spouses Name: ______________________________

PATIENT CONTACT INFORMATION

Address: ____ City: ______________________

State: ______ Zip: ________ Email:____________________@____________________

Cell: (_____) ______- ________ Home #: (____) _____-_______ Work #: (____) _____-_______ Preferred # C H W

How did you hear about us? ________________________ Referred By: ______________________

IN CASE OF EMERGENCY:

Name: ______________________ Phone: (_____) ______ - ________ Relationship: ________________

WORK INFORMATION

Occupation: ____________________ Employer: ________________________ Yrs. Employed: _____

Employers Address: ____________________________ City: ______________ State: ____ Zip: ________

Have you missed time from work because of accident? Y N or Have you been unable to work since the accident? Y N

If Yes: Full-Time off work: ____________ to ____________ ____________ to ____________

Part-Time off work: ____________ to ____________ ____________ to ____________

HISTORY OF OCCURANCE

Date of Accident: ___________ Time: __________ AM/PM

Driver of Car: ______________________ Where were you seated: ____________________

Who owns the car: ___________________ Year and Model of car: ____________________

What was the approximate damage done to the car you were in:$ ___________

Visibility at the time of accident: ☐ Poor ☐Fair ☐Good

Road Conditions at the time of accident (Circle all that applies): ☐ Icy/Rainy ☐Wet ☐Clear ☐Dark

Your Car: ☐Hit another car or Was hit in the: ☐Right ☐Left ☐Rear ☐Front ☐Side

Type of accident: ☐Head on collision ☐Broad side-collision ☐Rear-End Collision ☐Front impact, rear-ended car in front ☐Non-Collision: ______________________________

INDICATE ON THESE DIAGRAMS HOW THE ACCIDENT HAPPENED

IMPACT/SEAT BELT/HEADREST/SPEED

Describe in your own words what happened to you upon impact: ______________________________

____

Did you see the accident coming? ☐YES ☐NO Were seatbelts worn? ☐YES ☐NO

Were you pre-warned that the accident was about to happen? ☐YES ☐NO

Does your car have headrests? ☐YES ☐NO

If YES, what was the position of those headrests compared to your head before the accident?

☐Top of headrest even with BOTTOM of head

☐Top of headrest even with TOP of head

☐Top of headrest even with MIDDLE OF NECK

Was your car braking? ☐YES ☐NO Was your car moving at the time of accident ☐YES ☐NO

If YES, how fast would you estimate you were going? _____ MPH (estimate)

How fast was the other car traveling? _____ MPH (estimate)

HEAD/BODY POSITION/ABLE TO MOVE BODY

Head/Body position at time of impact ☐Head turned: ☐Right ☐Left ☐Head looking back ☐Head straight forward ☐Body straight in sitting position ☐Body rotated: ☐Right ☐Left

At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car:

____

As a result of the accident you were: ☐Rendered unconscious ☐Dazed, circumstances vague ☐Shaken up but could function.

Could you move all parts of your body? ☐YES ☐NO If no, what and why? ______________

Were you able to get out of the car and walk unaided? ☐YES ☐NO If no, why not? ______________

____

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? ☐YES ☐NO

If yes, what bleeding cuts did you get from this accident? ______________

If yes, what bruises did you get from this accident? ______________

Please describe how you felt. PLEASE BE SPECIFIC

Immediately after the accident: ______________

Later that ☐DAY ☐NIGHT: ______________

The next day(s): ______________

Check symptoms apparent since the accident:

☐Headache	☐Dizziness	☐Loss of memory	☐Sleeping problems
☐Neck pain/stiffness	☐Fainting	☐Fatigue	☐Numbness in toes
☐Mid-back pain	☐Ringing/buzzing ears	☐Tension	☐Numbness in fingers
☐Low-back pain	☐Loss of balance	☐Shortness of breath	☐Cold hands
☐Eyes sensitive to light	☐Loss of smell	☐Irritability	☐Cold feet
☐Pain behind eyes	☐Loss of taste	☐Depression	☐Diarrhea
☐Constipation	☐Chest Pain	☐Nervousness	☐Cold Sweats
☐Anxious	☐Other ______________		

PAIN LEVEL/SCALE OF RECOVERY

On a scale of 0-10, with 0 being (examiner's quote), "You're pain free and can function quite well," and 10 being, "You're in pain all the time and cannot function at all," where would you rate yourself?

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
0	1 2 3	4 5 6	7 8 9	10

Please explain why: ______________

Relative to where you were before this injury, how would you rate how much you have recovered so far? _____ %

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? ☐YES ☐NO

If yes, how did you get there? ☐Someone else drove me ☐Drove own car ☐Ambulance ☐Police

DOCTOR 1/HOSPITAL/CLINIC SEEN: ______________________ Date of visit:____/____/_____

Were you examined? ☐YES ☐NO Were X-rays taken? ☐YES ☐NO

Were you given treatment? ☐YES ☐NO

If yes, what treatment was given to you? ______________________

What benefits did you receive from the treatment? ______________________

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints just before the accident? ☐YES ☐NO

If yes, please describe in detail: ______________________

PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing? ☐YES ☐NO

If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): ______________________

____

ACTIVITES OF DAILY LIVING

Do you notice any activities of your home daily routines that are different now than before the accident?

☐YES ☐NO If yes, list them as:

Those activities that you are unable to do are (be specific): ______________________

Those activities that are painful to do are (be specific): ______________________

Those activities that are difficult to do are (be specific): ______________________

AUTOMOBILE ACCIDENT – INSURANCE DATA

Patient's Insurance Company Information

Company Name: ______________________ P: (____)_____-______ Policy #: ______________

P.O. Box/Street Number: ______________________ City: ______________

State: ____ Zip: ________ Adjuster's Name: ______________________ Claim No. ______________

Insured's Insurance Information

Insured's name if other than patient: ______________________ P: (____) ____ - ______

Company Name: ______________________ P: (____)_____-______ Policy #: ______________

P.O. Box/Street Number: ______________________ City: ______________

State: ____ Zip: ________ Adjuster's Name: ______________________

Other Driver's Insurance Information

Other Driver's Name (if another car was involved): ______________________ P: (____) ____ - ______

Company Name: ______________________ P: (____)_____-______ Policy #: ______________

P.O. Box/Street Number: ______________________ City: ______________

State: ____ Zip: ________ Adjuster's Name: ______________________

ATTORNEY ON CASE

Do you have an attorney on this case? ☐YES ☐NO

If yes, who? Name: ______________________ P: (____) ____-______

Address: ______________________ City: ______________ State: ____ Zip: ______

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient ______________________________

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ]	Age [ ]	SISTER(S) Age [ ]	Age [ ]	CHILDREN Age [ ]	Age [ ]	Age [ ]
Arthritis										
Asthma - Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize Caring Chiropractic Center,P.A. to release any medical information necessary to process my insurance claim(s) with regards to my condition while under their observation or treatment. They are authorized to provide this information in accordance with an injury protection endorsement of a policy with ____________________ .
(company)

Signature ______________________________ Date ________________ Witness ______________________

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDE CARE

I hereby authorize the ________________Insurance Company/Insurance Administrators to pay by check made out and mailed directly to: Caring Chiropractic Center, P.A., 10811Xavis St NW, Coon Rapids, MN 55433 for the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner any balance of said professional 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 ______________________

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

Kenneth H. Ruf, D.C.
Caring Chiropractic Center, P.A.
10811 Xavis Street NW
Coon Rapids, MN 55433

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____

____

I do hereby authorize Kenneth H. Ruf, D.C. to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on ______________________.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: ____________________ Patient's signature: ________________________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated ______________________ Authorized signature: ______________________________

NOTICE: Please date, sign, and return one copy to doctor's office at once.