

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD:**LOCALIZATION**

- | | | |
|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Malaria | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> Lumbago | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer |

Pain Scale 0 1 2 3 4 5 6 7 8 9 10

P- pain T- tender N- numb S - spasm

Write a letter where you are feeling symptoms.

CHECK ANY YOU HAVE OR HAVE HAD REPEATEDLY IN THE PAST 5 YEARS:**GENERAL SYMPTOMS**

- Headache
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Fatigue
- Nervousness
- Loss of weight
- Numbness or pain in face, arms, hands or legs
- Allergies
- Neuralgia

EYES, EARS, NOSE

- Nearsightedness
- Failing vision
- Crossed eye
- Eye pain
- Deafness
- Earaches
- Ear noises/discharge
- Nasal drainage
- Nose bleeds
- Nasal obstruction
- TMJ
- Jaw clicking
- Dental decay/gum trouble
- Enlarged glands
- Asthma
- Hay fever

SKIN

- Skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Hives
- Allergies

GASTROINTESTINAL

- Poor appetite
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting blood
- Pain over stomach
- Stomach distention
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids (piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

THROAT

- Sore throat
- Hoarseness
- Tonsillitis
- Frequent thyroid

GENITOURINARY

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Prostate trouble

FEMALE

- Painful menstruation
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Lumps in breast
- Menopausal symptoms

MUSCLE & JOINT

- Stiff neck
- Back ache
- Swollen Joints
- Tremors
- Painful tail bone
- Foot trouble
- Pain between shoulders
- Hernia
- Spinal curvature
- Faulty posture

RESPIRATORY

- Chronic Cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing
- Asthma
- Emphysema

CARDIO-VASCULAR

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart attack
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE ACCIDENTAL INJURY FORM

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Doctor's Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Patient agrees to pay 1½% per month on delinquent accounts over 90 days and any legal/collection fees.

Patient/Guardian's Signature _____ S.S.# _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Date of Accident _____ Hour _____ AM ___ PM ___ Location _____

How did the accident occur? Auto Collision On the job injury Other _____

If not an auto collision, please describe circumstances _____

Did you report the injury to your foreman or employer? Yes No

Did he (they) recommend care at our office? Yes No

If an auto accident, were you Driver Passenger Pedestrian

If an auto collision, were you struck from Behind Right side Left side Front Auto was parked

Did your car strike the other(s) involved? Yes No Did the other auto strike yours? Yes No

As a result of the accident, were traffic citations issued to you? Yes No

To the driver of the other car? Yes No To the driver of your car? Yes No

List the extent of the injuries as you know them _____

Did you require post-accident hospitalization? Yes No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|--|---|---|---|--------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fever | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Heavy head | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above _____

Have you lost any days of work? _____ Dates: _____

Insurance companies involved : _____

Phone numbers _____

Claim number _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No

Attorney name _____ Phone # _____

N

W

E

Description of accident -
Vehicle #1 - you

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