Parrish Chiropractic Center, P.C.

Personal Injury - Patient History

Today's Date _________

Patient's Name ________________________________ Soc. Sec. # __________________

Address _______________________Apt. # ____ City ____________ State ____ Zip______

Age _______ Birth Date ______________ Marital Status: M S D W # Children _______

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ____

Occupation ________________________ Employer ______________________________

Employer's Address ____

Do You Have Health Insurance? ☐ Yes ☐ No Name: _____________ Policy #: __________

Auto Insurance Name: __________________________ Policy #: ___________________

Do You Have An Attorney? ☐ Yes ☐ No Name: _________________ Phone #: __________

Major Complaint: ____

____

____

Is This Condition Related to: ☐ Auto Accident ☐ Work ☐ Fall ☐ Other _________________

Is This Condition Getting: ☐ Better ☐ Worse ☐ Same

Did You Have A Similar Complaint Prior To Your Injury? ☐ Yes ☐ No

Date of Accident: ______________ Reported To Insurance Co. &/or Employer? ☐ Yes ☐ No

Were The Police Notified? ☐ Yes ☐ No

Did You Go To The Hospital? ☐ Yes ☐ No Name of Hospital: _____________________

If Yes, When? ☐ Immediately Following Accident ☐ Later That Day ☐ Other _____________

How Did You Get To The Hospital? ☐ Ambulance ☐ Private Transportation

Were You Admitted To The Hospital? ☐ Yes ☐ No How Long Did You Stay? ___________

Were X-rays Taken? ☐ Yes ☐ No Was Medication Prescribed? ☐ Yes ☐ No

Have You Seen Other Doctors For This Condition? ☐ Yes ☐ No Who? _________________

Check Any Of The Following You Have Noticed Since Your Injury:

☐ Headaches	☐ Arm Numbness	☐ Nervousness	☐ Head Feels Heavy
☐ Neck Pain	☐ Mid Back Pain	☐ Tension	☐ Ringing In Ears
☐ Neck Stiffness	☐ Low Back Pain	☐ Dizziness	☐ Difficulty Sleeping
☐ Shoulder Pain	☐ Leg Pain	☐ Fatigue	☐ Abdominal Pain
☐ Arm Pain	☐ Leg Numbness	☐ Chest Pain	☐ Diarrhea

Other:____

____

Nature of accident:

Describe the accident in your own words ____
____
____

Were you the: □ driver □ passenger If passenger, were you sitting in □ front □ right rear □ left rear

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

Was the impact from: □ the front □ the right side □ the left side □ behind

Approximate speed of your car: _________m.p.h. Other car: _________m.p.h.

At the time of impact, were you looking: □ straight ahead □ out rear view mirror □ to the left □ to the right

Were you braced for impact? □ Yes □ No Were you wearing your seat belt? □ Yes □ No

Did you strike anything in your vehicle at the time of impact? □ Yes □ No

If yes, specify: □ steering wheel □ dashboard □ windshield □ side door □ side window □ other _________

Struck which part of body: □ chest □ head □ shoulder □ arm □ hand □ knee □ other: __________________

Were you knocked unconscious? □ Yes □ No In a daze? □ Yes □ No

Immediately following the accident, how did you feel? ______________________________________

Have you lost time from work as a result of this accident? □ Yes □ No If yes, how much? ______________

Do you notice any activity restrictions as a result of this injury? □ Yes □ No If yes, please describe: _______
____
____

Have you ever been involved in an accident before? □ Yes □ No If yes, please list date, type of accident, as well as injuries
received:____

List any previously diagnosed health conditions: ____

List any major surgical operations and year occurred:
____

Women: are you pregnant at this time? □ Yes □ No

Payment Acknowledgment (please Sign)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection 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 or my dependent will be immediately due and payable. Outstanding balances over 30 days may be assessed interest charges at the rate of 1.5% monthly.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature: **X** ____ Date __________________

Guardian or Spouse's
Signature Authorizing Care: ____________________________________ Date __________________

I hereby authorize and direct my insurance benefits to be paid directly to the Doctor. I am financially responsible for non-covered services.

Patient's Signature: **X** ____ Date __________________