Berglund Chiropractic & Wellness, LLC

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 _____