WELCOME TO HESS spinal centers

PATIENT INFORMATION

DATE _____

NAME _____

ADDRESS _____

_____
CITY STATE ZIP

DATE OF BIRTH _____ AGE _____

S.S.# _____ SEX ☐ M ☐ F

MARITAL STATUS: ☐ SINGLE ☐ MARRIED
☐ WIDOWED ☐ DIVORCED

HEIGHT _____ WEIGHT _____

EMPLOYER _____

OCCUPATION _____

PHONE NUMBERS

HOME _____ WORK_____

CELL PHONE _____

IN CASE OF EMERGENCY, CONTACT:

NAME _____

RELATIONSHIP _____

HOME PHONE _____

WORK PHONE _____

INSURANCE INFORMATION

AUTO INSURANCE (PIP) _____

DID YOU REPORT THE ACCIDENT TO YOUR AUTO INSURANCE COMPANY? ☐ YES ☐ NO

CLAIM # _____

INSURANCE COMPANY TEL # _____

RELATIONSHIP TO INSURED _____

HEALTH INSURANCE _____

GROUP # _____ MEMBER ID _____

HEALTH INSURANCE TEL # _____

RELATIONSHIP TO INSURED _____

MEDICAL HISTORY

DO YOU HAVE ANY MAJOR OR CHRONIC ILLNESS?
☐ YES ☐ NO IF YES, PLEASE MARK X ON THE FOLLOWING IF APPLICABLE:

☐ AIDS/HIV
☐ ANEMIA
☐ ANOREXIA
☐ APPENDICITIS
☐ ARTHRITIS
☐ ASTHMA
☐ BLEEDING DISORDERS
☐ BREAST LUMP
☐ BRONCHITIS
☐ BULIMIA
☐ CANCER
☐ DIABETES
☐ EMPHYSEMA
☐ EPILEPSY
☐ FRACTURES
☐ GLAUCOMA
☐ GONORRHEA
☐ HEART DISEASE
☐ HEPATITIS
☐ HERPES
☐ HIGH BLOOD
☐ PRESSURE
☐ OSTEOPOROSIS
☐ PACEMAKER
☐ PNEUMONIA
☐ STROKE
☐ OTHER _____

DO YOU HAVE A FAMILY HISTORY OF ANY MAJOR ILLNESS OR HEREDITARY CONDITION? ☐ YES ☐ NO
IF YES, PLEASE MARK X ON THE FOLLOWING IF APPLICABLE:

☐ AIDS/HIV
☐ ASTHMA
☐ CANCER
☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE
☐ OTHER _____
☐ EPILEPSY
☐ GLAUCOMA
☐ DIABETES
☐ HEPATITIS
☐ STROKE

ARE YOU NOW TAKING OR HAVE YOU TAKEN ANY MEDICATION IN THE LAST YEAR?
☐ YES ☐ NO IF YES, PLEASE DESCRIBE _____
_____

HAVE YOU HAD ANY HOSPITALIZATIONS OR SURGERIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:
1. _____ DATE _____
2. _____ DATE _____
3. _____ DATE _____
4. _____ DATE _____

HAVE YOU EVER BEEN IN ANY <u>OTHER</u> ACCIDENTS OF ANY KIND IN THE PAST? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE _____
_____
_____
_____

HAVE YOU EVER BEEN TREATED FOR ANY NECK OR BACK PROBLEMS IN THE PAST?
☐ YES ☐ NO IF YES, PLEASE DESCRIBE _____
_____

DO YOU HAVE ANY TYPE OF DISABILITY OR IMPAIRMENT RATING? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE _____
_____

ACCIDENT INFORMATION

DATE OF ACCIDENT _____

LOCATION _____

MAKE AND MODEL OF VEHICLE YOU WERE IN:

_____

WERE YOU WEARING A SEATBELT? □YES □NO

DID YOUR CAR IMPACT ANOTHER VEHICLE?
□YES □ NO

DID YOUR CAR IMPACT A STRUCTURE? □YES □ NO
IF YES EXPLAIN: _____

_____

WERE YOU: □ DRIVER □ FRONT PASSENGER
□ REAR LEFT PASSENGER □ REAR RIGHT PASSENGER
□PEDESTRIAN

DID ANY PART OF YOUR BODY STRIKE ANYTHING IN THE VEHICLE? □ YES □ NO IF YES, DESCRIBE:
□ HEAD REST □ STEERING WHEEL □SIDE WINDOW □ OTHER

_____

WAS IMPACT FROM:
□FRONT □REAR □LEFT □RIGHT □OTHER _____

AT THE TIME OF IMPACT WERE YOU:
□LOOKING STRAIGHT AHEAD □LOOKING RIGHT
□LOOKING TO THE LEFT □LOOKING DOWN
□LOOKING UP

WERE YOU: □SURPRISED BY IMPACT
□BRACED FOR IMPACT

DID THE POLICE COME TO THE ACCIDENT SITE?
□YES □ NO
WAS A POLICE REPORT FILED? ρYES ρ NO
WAS A TRAFFIC VIOLATION ISSUED? ρYES ρ NO
IF YES, TO WHOM? _____

ACCIDENT DESCRIPTION: _____

_____

_____

_____

HOSPITAL INFORMATION

DID YOU GO TO THE HOSPITAL? □ YES □ NO

IF NO, CONTINUE TO NEXT SECTION

IF YES, NAME OF HOSPITAL _____

HOSPITAL INFORMATION (CONT'D)

WERE YOU TAKEN <u>IMMEDIATELY</u> TO THE HOSPITAL? □YES
□ NO BY WHOM?

_____

_____

IF YOU <u>DID NOT</u> GO IMMEDIATELY TO THE HOSPITAL, WHEN DID YOU GO? _____

_____

WERE YOU ADMITTED? □ YES □ NO
IF YES, HOW LONG? _____

TO THE BEST OF YOUR KNOWLEDGE WHAT WAS DONE AT THE HOSPITAL? □EXAM □STITCHES □X-RAYS □BRACES
□MEDICATION PRESCRIBED WHAT TYPE?

_____

_____

OTHER DOCTOR INFORMATION

IF YOU <u>DID NOT</u> GO TO THE HOSPITAL, DID YOU CONSULT A PHYSICIAN BEFORE YOU CAME TO THIS OFFICE?
□ YES □ NO IF NO, CONTINUE TO NEXT SECTION

IF YES, NAME OF DOCTOR CONSULTED:

_____

WHAT DID HE/SHE SAY WAS WRONG WITH YOU?

_____

ARE YOU STILL UNDER HIS/HER CARE? □ YES □ NO
IF YES, DATE OF LAST VISIT _____

DID YOU SEE ANY OTHER DOCTORS FOR FOLLOW UP?
□ YES □ NO
IF YES, PLEASE ANSWER: □CHIROPRACTOR □NEUROLOGIST
□ORTHOPEDIC SURGEON □ FAMILY DOCTOR

NAME OF DOCTOR	DATE OF FIRST VISIT
1._____ __	_____
2._____	_____
3._____	_____

DID YOU HAVE ANY SPECIAL TESTS PERFORMED?
□ YES □ NO

□MRI DATE _____
□CT DATE_____
□EMG DATE_____ _
□BONE SCAN DATE_____
□NERVE TESTS DATE_____
□OTHER DATE_____

SYMPTOMS/INJURIES CAUSED BY ACCIDENT

SINCE THE ACCIDENT IS YOUR PAIN GETTING WORSE? □YES □ NO □NO IMPROVEMENT □LITTLE IMPROVEMENT

GENERAL SYMPTOMS: □NERVOUSNESS □FATIGUE □IRRITABILITY □DEPRESSION □LOSS OF SLEEP □TENSION □NAUSEA

PLEASE ☑ AND MARK ON DIAGRAM ANY OF THE FOLLOWING SYMPTOMS YOU MAY HAVE:

□ **HEADACHES** 1.MILD 2.MODERATE 3.SEVERE

□**NECK PAIN** 1.MILD 2.MODERATE 3.SEVERE

□**SHOULDER PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**CHEST PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**ARM PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**ABDOMINAL PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**HAND PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**UPPER BACK PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**MID BACK PAIN** 1.LEFT 2.RIGHT 3.BOTH

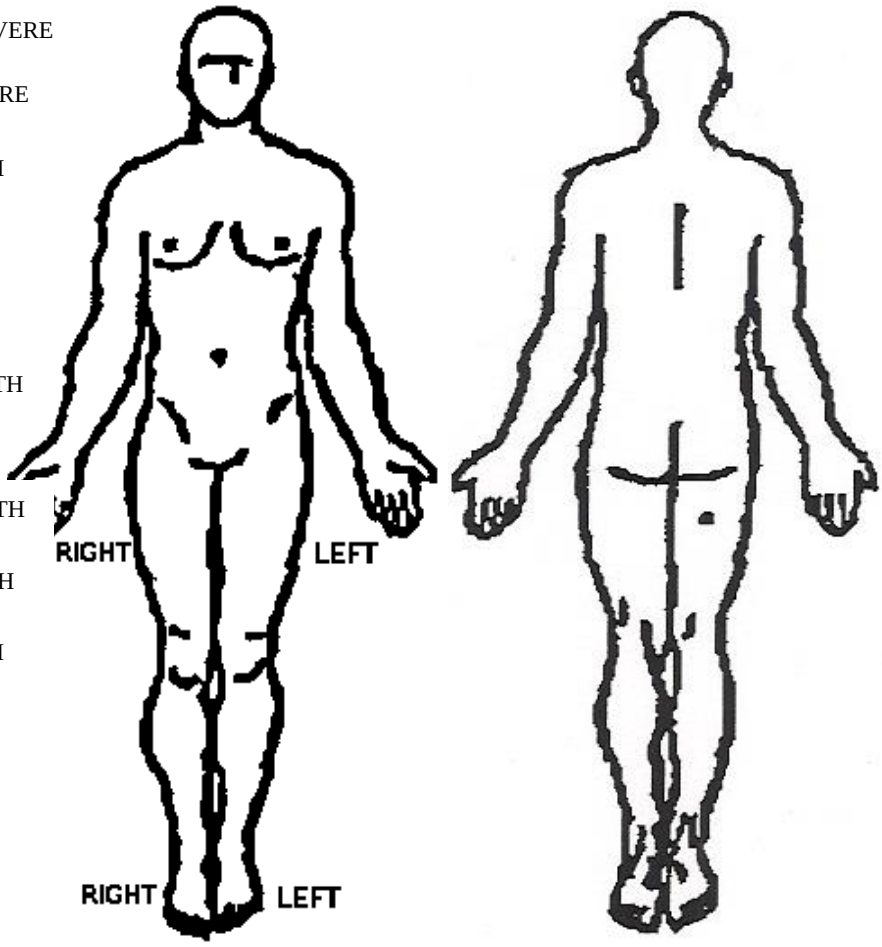
□**LOWBACK PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**LEG PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**KNEE PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**FOOT PAIN** 1.LEFT 2.RIGHT 3.BOTH

□**OTHER**_____



WORK STATUS

HAVE YOU LOST TIME FROM WORK? □YES □ NO

DATES _____

WAS IT BY DOCTORS ORDERS? □YES □ NO

ARE YOU NOW WORKING? □YES □ NO

WHEN DID YOU RETURN TO WORK? _____

ARE YOU WORKING IN PAIN? □YES □ NO

ATTORNEY INFORMATION

DO YOU HAVE AN ATTORNEY? □YES □NO

NAME _____

ADDRESS: _____

PHONE NUMBER: _____

FEMALES ONLY

ARE YOU PREGNANT? □YES □ NO □ DON'T KNOW
DATE OF LAST PERIOD: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE _____
PATIENT SIGNATURE