# GREATER DECATUR INJURY AND WELLNESS

Please complete this questionnaire. This confidential History will be part of your permanent records. Thank You.

## *CONFIDENTIAL PATIENT CASE HISTORY*

Name________________________ Date of Birth_______________ Sex M / F

Address________________________ City _______________ State_____ Zip________________

Soc. Sec #____________________ Home Phone____________________ Cellphone/Alt # ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of Children/ages____________________

Emergency Contact: Name:________________________ Phone #____________________

Occupation:________________________ Email Address:________________________

Reason for Dr's Visit today?________________________________________________

Date of Accident ________________________ Date when symptoms first appeared ____________________

Cause of Injury: ☐ Motor Vehicle Accident ☐ Slip/Fall ☐ Other

Have you had this or similar conditions in the past? ________________________

Does any body positions relieve the symptoms? ________________________

Does any body positions make it feel worse? ________________________

Is this Condition: ☐ Getting better ☐ Unchanged ☐ Getting Worse

List any Doctors or Therapist who have treated this condition:________________________

List any surgical operations and years:________________________

Name & Address of Primary Care Physician: ________________________

### ***AUTO ACCIDENT or PERSONAL INJURY INFORMATION***

Has a Lawyer been Retained? ☐ YES ☐ NO Name of Attorney ________________________

If no would you like one to contact you? ________________

### YOUR AUTO INSURANCE/WORKER'S COMPENSATION

Primary Insurance Company: ________________________ Address: ________________________

Phone # ____________________ Policy # ____________________ Group ____________________ Type: ☐ Group ☐ Private

Secondary Insurance Company: ________________________ Address: ________________________

Phone # ____________________ Policy # ____________________ Group ____________________ Type: ☐ Group ☐ Private

**Complete if Insured is Different than Patient**:

Insured's Name____________________ Insured's Date of Birth_______________ Relationship to Patient__________

Insured's Employer________________________________________________

### AT FAULT AUTO INSURANCE/WORKER'S COMPENSATION:

Insurance Company: ________________________ Address: ________________________

Adjuster's Name: ________________________ Phone #:____________________EXT: ______

Claim # ________________________ Policy #____________________ Date of Injury_______________

RELEASE AND ASSIGNMENT

*I authorize the release of any information necessary to process my insurance claims. I hereby assign and request payment directly to my health care provider.*

Patient's Signature:________________________________ Date:____________________

Parent/Guardian: ________________________________ Date:____________________

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## HEALTH HISTORY

Date _______________ Sex: ☐ Male ☐ Female ☐ Right Handed ☐ Left Handed

Name: ___________________________________________ Primary Care Physician ____________________________

Age: _____________ Height ___________ Weight ____________ Referring Physician ______________________________

## SYMPTOMS

(*please check if you currently have or have had in the past*)

**GENERAL**
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

**MUSCLE/JOINT/BONE**

Pain, weakness/numb
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Neck ☐ Feet
- ☐ Hands ☐ Shoulder

**GENITO-URINARY**
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Painful Urination

**GASTROINTESTINAL**
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

**CARDIOVASCULAR**
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose veins

**EYE, EAR, NOSE, THROAT**
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Ear Discharge
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

**SKIN**
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that will not heal

**MEN only**
- ☐ Breast Lump
- ☐ Erection difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

**WOMEN only**
- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Hot Flashes
- ☐ Nipple discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of Last Menstrual period _________

Date of Last Pap Smear_______________

Date of Mammogram _________________

Are You Pregnant? ☐ Yes ☐ No

## CONDITIONS

(please check conditions you have or have had in the past)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Sickle Cell Anemia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Kidney Disease
- ☐ Liver Damage
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Issue
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ______________________________________________

_____________________________________________________________________________________

LIST ALL ALLERGIES (i.e. Medicine, Shell Fish, Nuts, etc): ______________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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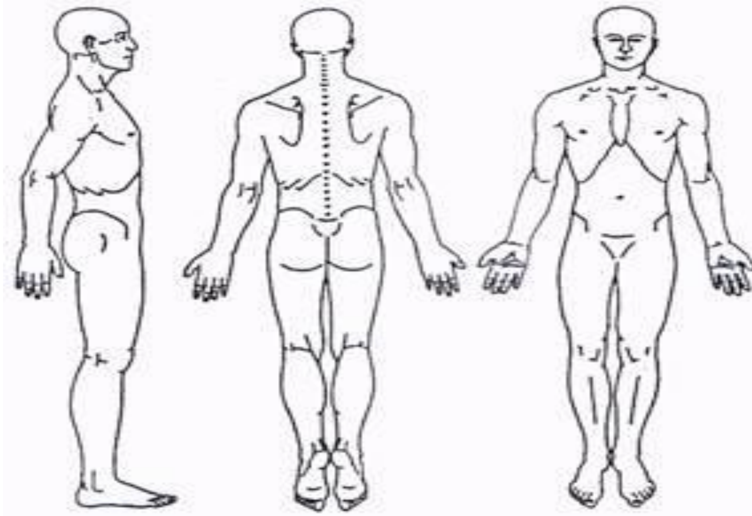
**PAIN QUESTIONNAIRE**

PATIENT NAME_____________________________________________ DATE____________________________

AGE__________ DATE OF BIRTH__________________ OCCUPATION_________________________________

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN**

**A= Ache  P= Pins and Needles  B= Burning  S = Stabbing  N= Numbness  O = Other**



**PLEASE RATE YOUR PAIN ON THE FOLLOWING SCALE (Please Circle)**

| | |
|---|---|
| **0** | **NO PAIN** |
| **1** | **VERY MILD** |
| **2** | **DISCOMFORTING** |
| **3** | **TOLERABLE** |
| **4** | **DISTRESSING** |
| **5** | **VERY DISTRESSING** |
| **6** | **INTENSE** |
| **7** | **VERY INTENSE** |
| **8** | **UTTERLY HORRIBLE** |
| **9** | **EXCRUCIATING UNBEARABLE** |
| **10** | **UNIMAGINABLE/UNSPEAKABLE** |

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## AUTOMOBILE ACCIDENT DESCRIPTION

Please answer the questions below. If you do not know the answer, please leave it blank.

**1. VEHICLE TYPE**
- ☐ Car ☐ SUV ☐ Van
- ☐ Truck ☐ Commercial Vehicle
- ☐ Bus ☐ Public transportation
- ☐ Other _______________

**2. YOUR POSITION IN VEHICLE**
- ☐ Driver ☐ Front Passenger
- ☐ Left Rear Passenger
- ☐ Right Rear Passenger
- ☐ Other _______________

**3. WHAT WAS YOUR VEHICLE DOING**
- ☐ Stopped in Traffic ☐ Stopped @ Light
- ☐ At Intersection ☐ Turning Right
- ☐ Slowing Down ☐ Turning Left
- ☐ Accelerating ☐ Other __________

**4. TIME/SPEED/DAMAGE**

Time of Accident ______ am/pm

Your Speed ______

Other Driver's Speed ______

**5. DETAILS OF ACCIDENT**

Visibility at time of accident

☐ Poor ☐ Fair ☐ Good

**6. ROAD CONDITIONS**

Road conditions time of accident:

☐ Icy ☐ Wet ☐ Sandy ☐ Dry ☐ Dark

**DAMAGE TO YOUR VEHICLE**

☐ Mild ☐ Moderate ☐ Totaled

**WHO HIT WHOM/WHAT?**
- ☐ You Hit Other Vehicle
- ☐ Other Vehicle Hit You
- ☐ You Hit Object ___________

**POINT OF IMPACT**
- ☐ Head On ☐ Left Front ☐ Right Front
- ☐ Rear-end ☐ Left Rear ☐ Right Rear

**7. BODY POSITION, ETC**

Did you see the accident coming? ☐ Yes ☐ No

Were You braced for the accident? ☐ Yes ☐ No

Did you have your seat belt on? ☐ Yes ☐ No

Did you have shoulder strap? ☐ Yes ☐ No

Did the Driver's Air Bags Deploy? ☐ Yes ☐ No

Did Side Air Bags Deploy? ☐ Yes ☐ No

Does Your Vehicle Have Head Rests? ☐ Yes ☐ No

Position of your headrest at the time of impact?

☐ Even Top of Head ☐ Even bottom of head ☐ Middle of Neck

What was the direction of your head at impact?

☐ Facing Forward ☐ Turned Right ☐ Turned Left

Did Passenger Air Bags Deploy? ☐ Yes ☐ No

**8. ADDITIONAL ACCIDENT INFORMATION:**______________________________________________

______________________________________________________________________

**9. DURING THE ACCIDENT**

Did your body strike the inside of the vehicle ☐ Yes ☐ No

If yes, Describe ________________________________

Did you Lose Consciousness? ☐ Yes ☐ No

If Yes, How Long ________________________________

Did the Police Show up at the scene? ☐ Yes ☐ No

Was accident report filed ☐ Yes ☐ No

**10. AFTER THE ACCIDENT**

**Check off your symptoms felt following the accident**:
- ☐ Headache ☐ Dizziness ☐ Mid Back Pain
- ☐ Neck Pain ☐ Nausea ☐ Low Back Pain
- ☐ Neck Stiffness ☐ Confusion ☐ Nervousness
- ☐ Depression ☐ Tension ☐ Anxious
- ☐ Lacerations, If so where_________________________________
- ☐ Other_____________________________________________

**11. EMERGENCY ROOM**

Where did you go after the accident?

☐ Home ☐ Work ☐ Hospital ☐ Doctor

How did you get there?

☐ Drove self ☐ Ambulance ☐ Friend/Family

Were X-rays Taken? ☐ Yes ☐ No

If yes, what areas: ________________________

Type of Lab Work ___________________________

Medications Given ☐ Yes ☐ No

If yes, please list: __________________________

**12. TREATMENT HISTORY**

Fill in if you have seen another doctor prior to this visit:

1. ________________________________ Date of visit_________
2. ________________________________ Date of visit_________

Types of Treatment Received ___________________________

Any other Tests (MRI, CAT SCAN) ______________________

Date of Last Visit ____________________________________

Attorney Name:________________________________

Attorney Phone Number: ________________________

AUTO INSURANCE ADJUSTOR____________________________

AUTO ADJUSTOR'S NUMBER ___________________ EXT:_____

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**AUTHORIZATION AND RELEASE**
**CONSENT FOR TREATMENT**

I, the undersigned hereby authorize the Doctors of **Greater Decatur Injury and Wellness** and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment when necessary. I, also, certify that no guarantee or assurance has been made to the results that they may be obtained.

I understand and agree that accident insurance policies are an arrangement between and insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature ___________________________________ Date ____________ Witness ____________________________

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature ___________________________________ Date ____________ Witness ____________________________

**REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE**

I hereby authorize the _________________________________ (*Insurance company/Insurance Administer*) to pay by check, and for it to be mailed directly to **Greater Decatur Injury and Wellness** the expense benefits allowable and otherwise payable to me under my current policy and other wise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable 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 ____________________________

**ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE**

I, the undersigned patient, am directing my Attorney, ________________________________ to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Patient's Signature ___________________________________ Date ____________ Witness ____________________________

**CONSENT FOR** ***TREATMENT OF A MINOR***

*I hereby authorize the Doctors of* **Greater Decatur Injury and Wellness** and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my ______________________________(indicate relationship to child) _________________________ (child's name).

Guardian's Signature ___________________________________ Date _____________ Witness __________________________

**X-RAYS/MEDICAL RECORDS RELEASE**

I have requested the release of record of ____________________________(patient's name) which are part of the records at **Greater Decatur Injury and Wellness**. I hereby request and authorize you, your employees, and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment, or opinion concerning any condition that may have had in the past, no have or may have in the future.

Please forward this information to Greater Decatur Injury and Wellness Decatur, GA 30032.

Patient's Signature ___________________________________ Date ____________ Witness ____________________________

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