Dr. Joseph Esposito DC

HEALTH PLUS
CHIROPRACTIC• ORTHOPEDICS
CLINICAL NUTRITION • PAIN MANAGEMENT

Last Name: _____

Confidential Patient Health Record

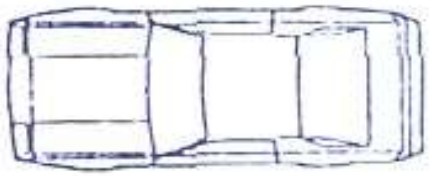
PERSONAL INJURY PATIENT HISTORY

Please check all appropriate responses:

Today's Date:_____/_____/20___
Last Name: _____
First Name: _____
Address: _____
City:_____
State:_____Zip Code: _____
Home Phone: (____)_____-_____
Work: Phone: (____)_____-_____
Cell phone: (____)_____-_____
Birth Date: ____/____/____
Sex: ☐ male ☐ female
E-mail:_____@_____._____
☐ Check the box to the left if you would like to receive Dr. Joe's Newsletter at the email address specified above.

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Title: ☐Mr. ☐ Ms. ☐Mrs. ☐Miss ☐Dr. ☐Rev.☐Hon.
Social Security #_____-_____- _____
Work Status ☐ unemployed ☐ full time ☐ part time ☐ retired ☐ disabled / not working ☐ self-employed
Occupation:_____
Employer: _____
Business Phone: (____)_____-_____
Address: _____
City:_____State:_____Zip: _____

1. Date of Accident:_____/_____/_____ 2. Time of Accident:_____AM/PM
3. Driver of Car: ☐Self ☐Other: _____
4. Where were you seated? ☐Driver's seat ☐Other: _____
5. Who owns the car? _____
6. Year & Model of your car. _____
7. Year & Model of the other car._____
8. What was the approximate damage done to your car? $ _____
9. Visibility at time of accident: ☐poor ☐fair ☐ good ☐ other: _____
10. Road conditions at time of accident: ☐icy ☐ rainy ☐wet ☐ clear ☐ dark ☐other describe):_____
11. Where was your car struck?

FRONT  REAR

In your own words, please describe accident_____

_____

_____

12. Type of Accident: ☐Rear impact (hit from behind) ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact ☐ Rear-ended car in front ☐ Non-collision

Office use only:

ROF Date: _____ Visit type: _____

Acct ID _____ Case ID _____Scanned Date _____ Completed Date _____ Int. _____ _____

13. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

_____

14. Did you see the accident coming? ☐ yes ☐ no

15. Did you brace for impact? : ☐yes ☐no

16. Were seatbelts worn? ☐yes ☐no

17. Does your car have headrests? ☐yes ☐no

18. If yes, what was the position of those headrests compared to your head before the accident? ☐ Top of headrest even with **bottom** of head ☐Top of headrest even with **top** of head ☐Top of headrest even with **middle** of neck

19. Was your car braking? ☐ yes ☐ no

20. Was your car moving at the time of the accident? ☐yes ☐no

21. If yes, how fast would you estimate you were going?_____mph

22. How fast would you estimate the other car was going?_____mph

23. Head/Body position at the time of impact: ☐ Head turned left/right ☐ Body straight in sitting position ☐ Head looking back ☐ Body rotated right/left ☐ Head straight forward ☐Other_____

24. As a result of the accident you were: ☐Rendered unconscious ☐In shock ☐Dazed, circumstances vague Other: _____

25. Were you wearing a hat or glasses? ☐ yes ☐no

26. Could you move all parts of your body? ☐yes ☐ no

27. If no, what parts couldn't you move and why?

_____

28. Were you able to get out of the car and walk unaided? ☐Yes ☐No

29. If no, why not? _____

30. Did you get any bleeding cuts? ☐Yes ☐No If yes, where? _____

31. Did you get any bruises? ☐Yes ☐No If yes, where? _____

32. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

33. Please check symptoms apparent since the accident:

☐Headache	☐Loss of balance	☐Pain behind Eyes
☐Eyes Light Sensitive	☐Cold feet	☐Sleeping problems
☐Fainting	☐Chest pain	☐Loss of smell
☐Numbness in toes	☐Anxious	☐Fatigue
☐Loss of memory	☐Low Back Pain	☐Depression
☐Irritability	☐Neck pain/Stiffness	☐Tension

☐Diarrhea
☐Nervousness
☐Facial Pain
☐Mid back pain
☐Dizziness
☐Numbness in fingers
☐Loss of taste
☐Breath shortness
☐Ringing/Buzzing
☐Cold hands
☐Constipation
☐Cold Sweats
☐Clicking or Popping Jaw
☐Other _____

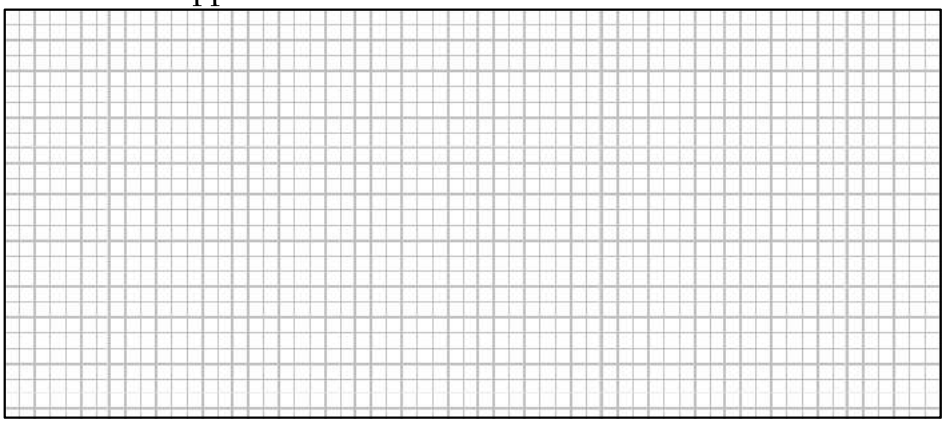
34. Occupation/Job Duties: _____
35. Employer: _____
36. Have you missed time from work: ☐yes ☐no
37. If yes, full time off work:_____to_____
38. If yes, part time off work:_____to_____
39. Did you seek medical help immediately after the accident? ☐yes ☐no
40. If yes, how did you get there? ☐Ambulance ☐Police ☐ Someone else drove me ☐Drove own car
☐Other: _____
41. Doctor #1: Name: _____
42. First Visit Date: _____
43. Were you examined? ☐yes ☐no
44. Were X-rays taken? ☐yes ☐no
45. Did you receive treatment? ☐yes ☐no ☐Medications ☐Braces ☐Collars
46. If yes, what kind of treatment did you receive? _____
47. What benefits did you receive from the treatment? _____
48. Date of last treatment: _____
49. Doctor #2: Name: _____
50. First Visit Date: _____
51. Were you examined? ☐yes ☐no
52. Were X-rays taken? ☐yes ☐no
53. Did you receive treatment? ☐yes ☐no
54. If yes, what kind of treatment did you receive? _____
55. What benefits did you receive from the treatment? _____
56. Date of last treatment:____/____/_____
57. Do you have an attorney on this claim? ☐yes ☐no
58. If yes, who? _____

Address _____

City_____State_____

Zip_____Phone (_____)_____-_____

Illustrate below how the accident happened:



Past Medical History: Please check and Describe:

☐None related to current complaints ☐Hospital or operation ☐Auto Accident ☐Work Accident ☐Illness ☐Other _____

Describe:_____

_____

_____

__

Family History: Please check ☐ **if any family member has suffered from:**

☐Tuberculosis ☐Mental Illness ☐ Gout ☐Hypertension ☐Kidney Disease ☐Epilepsy ☐Allergies ☐Cancer ☐Heart Attack ☐Spinal Disorder ☐Diabetes ☐Arthritis ☐Migraines ☐Other, list: _____

Personal History: Please check ☐ **if it applies, describe.**

Number of Children_____Number of Children at home_____

Employed Spouse ☐yes ☐no

Are you pregnant? ☐yes ☐no ☐not sure

Medications, describe _____

☐Disease, describe _____

☐Other, describe _____

SYSTEM REVIEW: Please check **the symptoms you know you have**

Genitourinary System

☐Bladder trouble ☐Painful urination ☐ Excessive urination ☐Discolored urine ☐Scanty urination

Gastro-Intestinal System

☐Poor appetite ☐Difficult swallowing ☐Vomiting food ☐Constipation ☐Hemorrhoids ☐Weight trouble ☐Excessive hunger ☐Excessive thirst ☐Abdominal pain ☐Black stool ☐Liver trouble ☐Difficult chewing ☐Nausea ☐Diarrhea ☐Bloody stool ☐Gall bladder trouble

Nervous System

☐Numbness ☐Dizziness ☐Muscle jerking ☐Confusion ☐Loss of feeling ☐Fainting ☐Convulsions ☐Depression ☐Paralysis ☐ Headaches ☐Forgetfulness

Cardio-Vascular System

☐Chest pain ☐Persistent Cough ☐Rapid heartbeat ☐Lung problems ☐Pain over heart ☐Coughing phlegm ☐High blood pressure ☐Varicose veins ☐Difficulty breathing ☐Coughing blood ☐Heart problems ☐Other

Eye, Ear, Nose and Throat System

☐Eye strain ☐Eye inflammation ☐Ear pain ☐Ear noises ☐Hearing loss ☐Nose pain ☐Nose discharge ☐Breathing difficulty ☐Sore mouth ☐Sore throat ☐Speech difficulty ☐Dental problems ☐Vision problems ☐Ear discharge ☐Nose bleeding ☐Sore gums ☐Hoarseness

Current Chief Compliant(s): Please check all **appropriate complaint areas.**

SPINE
☐Neck ☐Mid back ☐ Low back ☐Pelvis

UPPER EXTREMITY
☐ Shoulder R/L ☐Wrist R/L ☐ Arm R/L ☐ Forearm R/L ☐Elbow R/L ☐ Hand R/L

LOWER EXTREMITY
☐ Hip R/L ☐Leg R/L ☐Thigh R/L ☐Ankle R/L ☐Knee R/L ☐Foot R/L

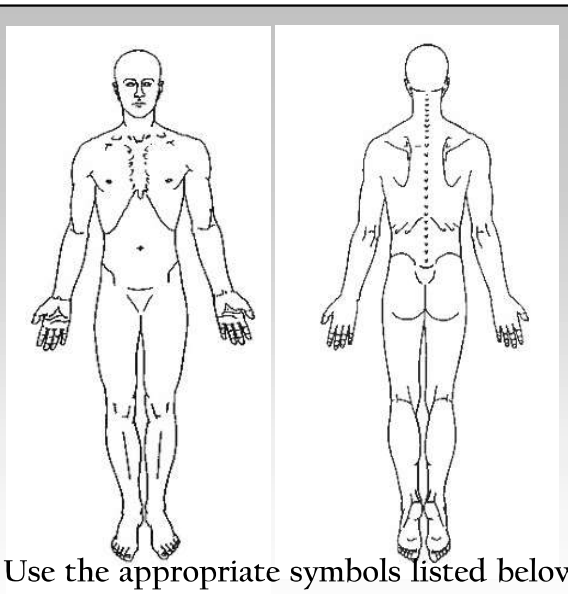
OTHER (describe):_____
_____
_____

Subjective Pain Level:

On a scale of 1-10 (10 being the worst)
Please check your current pain level.

NORMAL
☐ 0
LOW PAIN
☐ 1 ☐2 ☐3
MODERATE PAIN
☐ 4 ☐ 5 ☐ 6
INTENSE PAIN
☐ 7 ☐ 8 ☐ 9
EMERGENCY
☐ 10

Mark the areas on your body where
you feel the described sensations.
Mark stress points where the pain radiates.
Include all your affected areas.



Use the appropriate symbols listed below.

X (*NUMBNESS*) + (*BURNING*)

O (*PIN & NEEDLES*) = (*STABBING*)

Patient's Signature:_____Date_____/____/_____

Witness: _____

Consent for Treatment

I, the undersigned, herby authorize the Doctors of Health Plus 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 is necessary

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that accident insurance policies are an arrangement between an 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 Administrator to pay by check, and for it to be mailed directly to Health Plus Wellness the expense benefits allowable and otherwise 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 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 his 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 Minor

I hereby authorize the Doctors of Health Plus 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 of child),
_____(Child's name)

Guardian's Signature_____Date_____/____/_____
Witness_____

ASSIGNMENT OF BENEFITS AND DOCTOR'S LIEN

I,_____, hereby authorize Health Plus Wellness Centers to release to you a full report of findings, diagnosis, treatment and prognosis for me regarding injuries sustained in the accident in which I was involved on_____.

I direct you as my attorney to pay directly to Health Plus Wellness Centers all moneys owed to the doctor in consequence of this accident, as well as any other sums outstanding with the doctor. I authorize that these funds be withheld from any settlement made in this case.

I further give a lien on my case to Health Plus Wellness Centers against any and all proceeds of the settlement, judgment or verdict which may be paid to me or to you as my attorney as a result of the injuries sustained in the accident and treated by Health Plus Wellness Centers.

This lien does not supplant my own responsibility of outstanding medical bills, but is given as protection for the doctor and in consideration for this willingness to await delayed payment. I understand that payment of all outstanding fees to Health Plus Wellness Centers are payable upon demand and all are not contingent on the receipt of an award through settlement, judgment or verdict.

As a further inducement to accept a lien for my medical treatment, I hereby authorize and direct my attorney to communicate any offers of settlement to my doctor, and to discuss my case openly and fully with him/her. This authorization and direction is made in consideration for the acceptance of this lien. I understand that the doctor will send a copy of this authorization to my attorney, and direct my attorney to honor this obligation to communicate with my doctor. I also authorize my attorney to send my doctor, upon settlement, a copy of the settlement statement.

_____ _____

Patient *Date*

As the attorney of record for the above-named patient, I hereby agree to observe the terms of this agreement, and to withhold from any award in this case such sums as are required for the adequate protection of Health Plus Wellness Centers.

_____ _____

Attorney *Date*

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_____ _____

Patient *Date*

As the attorney of record for the above-named patient, I hereby agree to observe the terms of this agreement, and to withhold from any award in this case such sums as are required for the adequate protection of Health Plus Wellness Centers.

_____ _____

Attorney *Date*

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_____ _____

Patient *Date*

As the attorney of record for the above-named patient, I hereby agree to observe the terms of this agreement, and to withhold from any award in this case such sums as are required for the adequate protection of Health Plus Wellness Centers.

_____ _____

Attorney *Date*

WELLNESS CENTER

HEALTH PLUS

Concussion Questionnaire

Date of Injury: _____

Please use the following scale to rate your symptoms as listed below:

0 = Never Experienced
1 = Mild
2 = Moderate
3 = Severe
R = Resolved

Dizziness	0	1	2	3	R
Headaches	0	1	2	3	R
Hearing changes	0	1	2	3	R
Vision Changes	0	1	2	3	R
Balance Changes	0	1	2	3	R
Nausea and/or Vomiting	0	1	2	3	R
Light Sensitivity, bothered by bright light	0	1	2	3	R
Noise Sensitivity, bothered by loud noise	0	1	2	3	R
Sleep Disturbance	0	1	2	3	R
Fatigue, Tiring More Easily	0	1	2	3	R
Being Irritable, Easily Angered	0	1	2	3	R
Feeling Depressed or Tearful	0	1	2	3	R
Feeling Anxious or Tense	0	1	2	3	R
Poor Memory	0	1	2	3	R
Poor Concentration	0	1	2	3	R
Feeling Mentally Foggy	0	1	2	3	R

An overall score between 16 and 35 may be indicative of post-concussion syndrome, and greater than 35 may also be predictive of moderate to severe limitations in brain function.