

# AUTO ACCIDENT HISTORY FORM

## Patient Information

Patient Name: \_\_\_\_\_ Sex: Male Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Primary Phone #: Cell Home Work Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ #Hours/Week \_\_\_\_\_

Employer Address, City, State: \_\_\_\_\_

How did you hear about our office? *Online Search Website Drive By Special Event* \_\_\_\_\_

Spouse/Friend: Name \_\_\_\_\_ Physician \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you have a Primary Care Physician? No Yes Name: \_\_\_\_\_

Address or Clinic Location of Primary Care Physician: \_\_\_\_\_

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## AUTO & HEALTH INSURANCE INFORMATION: \*\*\* Please present all insurance documents to the front desk to copy.\*\*\*

Your Auto Insurance Co: \_\_\_\_\_ Policy in effect day of accident? Yes No Not Sure

Agent's Name: \_\_\_\_\_ Agent's Phone #: \_\_\_\_\_

Has accident been reported to your insurance agent? No Yes Day: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am pm

Do you have a claim number? No Yes # \_\_\_\_\_ Claims Adjuster Name: \_\_\_\_\_

Was there another vehicle involved? No Yes Auto Insurance of Other Vehicle: \_\_\_\_\_

Your Health Insurance Plan/s: \_\_\_\_\_

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## ACCIDENT INFORMATION: Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am pm

Describe the accident in your own words:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Were you the (circle):** Driver Front Passenger Rear Passenger Pedestrian

**How many people were in your vehicle at the time of the accident?** \_\_\_\_\_

Make & Model of your vehicle: \_\_\_\_\_ Were you wearing a seatbelt? No Yes

Did the airbags inflate? No Yes Don't have airbags Where was your headrest positioned? Low Middle High

What direction were you headed? \_\_\_\_\_ What was your speed at the time of the accident? \_\_\_\_\_ mph

Make & Model of other vehicle involved: \_\_\_\_\_ Speed of that vehicle: \_\_\_\_\_ mph

Road conditions were: Dry Wet Icy Other \_\_\_\_\_

**POLICE:** Did the police come to the site? No Yes Was a police report filed? No Yes Not Sure

Were there any witnesses? No Yes Not Sure \_\_\_\_\_

**IMPACT:** Did your care impact another vehicle or a structure (circle)? Another Vehicle A Structure

Was the impact to your vehicle from (circle): Front Rear Left Right Other: \_\_\_\_\_

Were you (circle): Surprised by the impact Braced for the impact

**Were you Unconscious at anytime during or after the accident?** No Yes Not Sure

If Yes or Not Sure Explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle? No Yes \_\_\_\_\_

**TREATMENT AFTER THE ACCIDENT:**

Did you go to the hospital? No Yes When? Immediately after Next Day 2 days or more after

How did you get to the hospital? Ambulance Private Transportation

Name of Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Tests** you had since the accident? None X-rays MRI CT scan Other \_\_\_\_\_

**Other Physicians** who have treated since accident: None \_\_\_\_\_

Any other treatment since the accident?: \_\_\_\_\_

**SYMPTOMS/INJURIES FROM THE ACCIDENT:**

**Have you missed any time from work since the accident?** No Yes #Hours \_\_\_\_\_ # Days \_\_\_\_\_

**Have you experienced any of the following symptoms since the accident? (Circle )**

Arm/ shoulder pain Back pain Chest pain Dizziness Ear Buzzing Ear ringing Fatigue Irritability Tingling/ Numbness in the hands/fingers Tingling/ Numbness in the feet/toes Headaches Jaw problems Leg pain Memory Loss

Nausea Neck pain Neck stiff Shortness of breath Sleep difficulty Stomach Upset Tension Vision blurred

Other Symptoms/Injuries: \_\_\_\_\_

Are your symptoms getting worse? No Yes Not Sure

Rate the severity of symptoms on a scale from 1 (least ) to 10 (severe) at **Rest:** \_\_\_\_\_ with **Activity:** \_\_\_\_\_

Do your symptoms radiate? No Yes Where: \_\_\_\_\_

Do you notice your symptoms during (circle): work sleep daily routine recreation sitting standing walking bending

Quality of Symptoms: Sharp Dull Burning Tingling Cramping Aching \_\_\_\_\_

**HEALTH HISTORY:**

Vitamins/Supplements: \_\_\_\_\_

Smoking: No Yes Packs/Day \_\_\_\_\_ Exercise: Type/Frequency: \_\_\_\_\_

Coffee/Caffeine: No Yes Cups/Day \_\_\_\_\_ Soda: No Yes Cans/Week \_\_\_\_\_ Alcohol: No Yes Drinks/Week \_\_\_\_\_

Stress Level: Low Moderate High \_\_\_\_\_

Work Activity Involves (circle): Sitting Standing Light Labor Heavy Labor Traveling Other: \_\_\_\_\_

Are you Right or Left Handed? Right Left **Females: Are you pregnant?** No Not Sure Yes Due Date: \_\_\_\_\_

List all past **Injuries or Accidents** (Year): \_\_\_\_\_

# Medical History

## Existing or Relevant Previous Conditions

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA (skin infection staph)	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High/Low blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

### Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates.

Describe any other conditions not listed above.

### Fall History

Injury as a result of a fall in the past year?  No  Yes \_\_\_\_\_

Two or more falls in the last year?  No  Yes \_\_\_\_\_

### Surgical History

Month / Day / Year

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

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### Current Medications currently not taking any medications

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

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Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

**Review of Systems:** Have you experienced any of the following in the **last few months?**

**Please circle and detail below. If you have no complaint in a category please circle "NONE".**

**General:** Fever Chills Swollen glands Loss of memory Weakness Aches/pains Weight loss/gain Cancer NONE

**Headaches:** Tension Migraines Premenstrual Other Frequency: \_\_\_\_\_ NONE

**Eyes:** Glasses/contacts Double vision Blurry vision Eye pain Glaucoma cataracts NONE

**Ear/Nose/Throat:** ear pain hearing loss ringing in ears nosebleeds sinus problems tooth pain hoarseness NONE

**Skin:** Rashes Changing moles Change in skin Other lesions Itchy skin Eczema Numbness NONE

**Cardio:** Irregular beat/palpitations Chest pain High blood pressure Pacemaker Heart attack date: \_\_\_\_\_ NONE

**Lungs:** Cough Cough up blood Wheezing Asthma Shortness of breath Sleep apnea NONE

**GI:** Poor appetite Indigestion/heartburn Nausea Vomiting blood Abdominal pain/cramps Constipation  
Diarrhea Change in bowel habits Rectal bleeding Liver disease Hepatitis Irritable bowel NONE

**GU/GYN:** Urinate at night more than once Blood in urine Burning or pain when urinating  
Problems passing urine Problems controlling urine Incontinence Menstrual problems NONE

**Neuro:** Weakness in extremity R L \_\_\_\_\_ Tingling or numbness Radiating pain Balance problems  
Sciatica dizziness Fainting spells Speech problems Seizures Stroke Head injury Concussion NONE

**Musculoskeletal:** Joint pain Swelling Muscle spasms Back or neck pain Sprain/strain fracture NONE

**Hemo:** Bleed or bruise easily Varicose veins Blood clots Lymph node pain/enlargement NONE

**Endocrine:** Constant thirst Always cold Always warm Very sluggish or tired Hot flashes NONE

**Family History:**

Is there a history of any of the following conditions in your family?

Diabetes Heart Attack Stroke Cancer Kidney Problems Arthritis Scoliosis Migraines Thyroid Disease  
High Blood Pressure High Cholesterol Other Inherited Diseases: \_\_\_\_\_

**CONSENT FOR DISCLOSURE OF INFORMATION:**

Our clinic has always been very protective and respectful of your personal information. Under the HIPAA Privacy Act we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

⇒ I give the clinic permission to leave a message on my voice mail / answering machine.  No  Yes  
Note: This statement applies to phone calls outside our usual appointment reminder calls.

⇒ I give the clinic permission to discuss my medical condition with another person.  No  Yes

If yes, please specify names. Parents: \_\_\_\_\_ Spouse: \_\_\_\_\_

Other: \_\_\_\_\_

X \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Signature of Patient, Parent or Guardian if under 18 years old**

**Consent for Treatment:**

I hereby give consent to the healthcare providers of Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC to render such care and treatment as might be required by my condition. Such care may include, but is not limited to consultations, examinations, digital x-rays, rehabilitative physical therapy, medical treatment, massage, wellness or maintenance care.

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient, Parent or Guardian if under 18 years old**

**HIPAA Privacy Policies: Consent for Use and Disclosure of Health Information**

I acknowledge that I have been made aware of the clinic’s privacy policies and may request a copy at any time. The policies are available in our reception area and on our website at [www.wellspringhopkins.com](http://www.wellspringhopkins.com).

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient, Parent or Guardian if under 18 years old**

**Payment Policy**

We will file claims with contracted and approved insurance plans as a courtesy. The clinic has the right to not accept non-contracted insurance plans at its discretion and in these cases; charges for services rendered are to be paid at the time of service, unless other arrangements have been made in advance. I understand that if I have not listed any insurance plan that I am responsible for the full amount of the visit unless other arrangements have been made in advance. Please note that affordable payment options and financial hardship plans are available if needed.

I understand that I am financially responsible for all charges whether or not paid by insurance, unless other arrangements have been made in advance. Any unpaid patient balance will accrue a 1 ½% monthly billing charge after 90 days. Any collection fees, attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.

**Assignment of Insurance Benefits**

I certify that I or my dependents have insurance through the insurance company information that I have provided and assign directly to Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

In the event that my insurance company forwards payment directly to me, instead of Wellspring Health Center, PLLC / Sports & Family Wellness PLLC, I will immediately deliver said payment to Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC.

I also verify that all the information contained on the history forms is true and correct to the best of my knowledge and belief. I authorize Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC to release my complete records to its business management company and/or to my insurance carrier(s) and or agents to secure payment of benefits; I also authorize Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC designation of representation for insurance claims appeals.

**Release of Records**

I authorize the release of my complete records to or from other physicians or medical facilities that may be pertinent and necessary to my care and treatment.

**Print Patient Name:** \_\_\_\_\_

X \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient, Parent or Guardian if under 18 years old**