Advanced PainCare

PATIENT REGISTRATION

NAME: _____ S.S.#: _____
(LAST) (FIRST) (INITIAL)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

OCCUPATION: _____ EMPLOYER: _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____ CELL PHONE:(_____)_____

EMAIL: _____ OKAY TO TEXT/EMAIL COMMUNICATION/UPDATES? ☐ Yes ☐ No

MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D BIRTH DATE: _____/_____/_____ AGE: _____ SEX: ☐ M ☐ F

RACE: ☐ WHITE ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: (_____)_____

PRIMARY CARE PHYSICIAN: _____ **PHONE #** _____

IF ON MEDICARE IS IT YOUR PRIMARY COVERAGE? ☐ Yes ☐ No

PRIMARY INSURANCE

INSURED NAME: _____ s.s.#: _____ BIRTH DATE: _____/_____/_____
(LAST) (FIRST) (INITIAL)

INSURANCE CARRIER: _____ POLICY # _____ GROUP #_____

CARRIER ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PHONE: (_____)_____ FAX: (_____)_____ CONTACT PERSON: _____

SECONDARY INSURANCE

INSURED NAME: _____ s.s.#: _____ BIRTH DATE: _____/_____/_____
(LAST) (FIRST) (INITIAL)

INSURANCE CARRIER: _____ POLICY # _____ GROUP #_____

CARRIER ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PHONE: (_____)_____ FAX: (_____)_____ CONTACT PERSON: _____

ADVANCED DIRECTIVE (LIVING WILL)

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ YES ☐ NO

WOULD YOU LIKE TO KEEP A COPY ON THE CHART? ☐ YES ☐ NO

PAYMENT AUTHORIZATION

I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician. I further authorize the release of any and all medical or other information related to such services to my insurance carrier in order to determine benefits due me. I agree to be personally and fully responsible for payment for medical services rendered. I understand that any balances not paid in a timely fashion are subject to additional financial and/or collection charges. I understand that if I cancel a clinic appointment, it must be within regular clinic hours at least one clinic day prior to my appointment, or a fifty dollar surcharge will be required prior to attending any future appointments. I consent to receive calls from Advanced PainCare for my protected healthcare and other services at the phone number(s) above, including my wireless number.

PATIENT SIGNATURE _____ DATE: _____

Michael Fishell, M.D.
2865 Siena Heights Drive, Suite 120
Henderson, NV 89052
(702) 932-0606
FAX: (702) 932-0605

FINANCIAL POLICY

You are financially responsible for the medical services you receive. Please review our policies below and print and sign your name at the end to indicate your agreement to these terms.

APPOINTMENTS

1. Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at that time, Advanced PainCare reserves the right to reschedule your appointment until such time you are able to make your copayment. Payment for any outstanding balance is due at your appointment unless previous payment arrangements have been made with the billing department.

2. Procedure Prepayment. Advanced PainCare collects your payment for a procedure at the time of service. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (If applicable) has been billed. In the event of an overpayment you may request a refund once we have received payment from your insurance carrier. We reserve the right to reschedule your procedure until pre-payment has been made.

3. Missed Appointments and Late Arrivals. If you are more than 15 minutes late, we may reschedule your appointment. Missed appointments are subject to a $50 No Show Fee. This fee is your responsibility and will not be billed to your insurance company.

INSURANCE PAYMENTS

4. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5. Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Advanced PainCare must submit a claim on your behalf to your insurer. If Advanced PainCare is unable to submit your claim within this period because we have not been supplied with your correct information, you will be responsible tor the charges. If your plan changes, or your insurer changes and we are not a contracted provider for that plan or insurer and we were not advised of this change prior to services being rendered, you will be responsible for all charges.

6. Self-Pay. If you do not have health insurance, or if your health insurances will not pay for services rendered by Advanced PainCare, you are considered a Self Pay patient. Your charges will be based on our current Self-Pay fee schedule (Available by request). Self Pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

7. Insurance Plan Participation. We participate in many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that Dr Fishell participates in your plan. Out of network benefits usually have higher deductibles and copayment.

8. Referrals and prior authorization requirements vary widely among insurance carriers and plans. If your carrier requires a referral for you to be seen by Advanced PainCare, it is your responsibility to be aware and to obtain this referral or authorization.

9. Prior Authorization and Non-Covered Services. Advanced PainCare may provide services that your insurance plan excludes or that require authorization. It is ultimately your responsibility to ensure that services being provided to you are a covered benefit and authorization has been obtained. Advanced PainCare, as a courtesy to our patients makes a concerted effort to determine if the services we order are covered by your insurance plan, and if so, whether or not prior authorization for treatment is required. If authorization is needed, we will request this on your behalf.

10. Out of Network payments. If we are not part of your insurance carrier's network and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Advanced PainCare immediately.

ACCOUNT BALANCES AND PAYMENTS

11. Reassignment of Balances. If your insurance company does not pay within a reasonable time, we may transfer the balance to your responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

12. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency, which may result in reporting to credit bureaus. Advanced PainCare reserves the right to refuse treatment to patients with outstanding balances over 120 days old.

13. Returned Checks will be subject to a $25 returned check fee.

14. Refunds for overpayment are made only after there has been full insurance reimbursement for all medical services on your account.

15. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of Advanced PainCare, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Advanced PainCare. I understand that I am financially responsible for all services I receive from Advanced PainCare. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Print Name: _____

Signed: _____ Date _____/_____/_____

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Patient Rights and Responsibilities

As a patient, you have the right:

- To be treated with respect and courtesy, including recognition of personal beliefs and values.
- To receive care in a setting and environment committed to patient safety.
- To privacy and confidentiality.
- To coordination and continuity of your health care.
- To know the identity of physicians and others involved in your care.
- To information presented in terms you understand, including treatment and care options.
- To be involved in decisions regarding your health care plan.
- To access health care records according to the Advanced PainCare Notice of Privacy Practices.
- To be heard if problems, complaints or grievances arise.
- To be informed of charges for services as well as payment options.

As a patient, you have a responsibility:

- To provide complete medical information to your health care providers, including a list of medications and devices for each visit.
- To ask questions so that you have a clear understanding.
- To make informed decisions.
- To report any changes in your health and medications.
- To report any changes in your health insurance plan and contact information, ie: address, phone numbers.
- To understand your health problems and to follow agreed upon plans and instructions for your care.
- To recognize the impact of your lifestyle choices on your personal health.
- To keep schedule appointments on time, or reschedule in a timely manner.
- To respect the rights, privacy and confidentiality of other patients and clinic personnel.
- To accept financial obligations and understand your own health insurance benefits.
- To treat Advanced PainCare staff and providers with respect and courtesy.

Print Name _____ Date _____/_____/_____

Signature _____

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I,_____, by signing this authorization am authorizing
(Patient Name)
confidential communication of my health information to the following recipients:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Medical Provider involved in my care_____

The type and amount of information to be disclosed is as follows:

- ☐ Complete Health Records
- ☐ Physical Exams
- ☐ Lab Results
- ☐ Consultation reports
- ☐ Appointments
- ☐ Billing Information
- ☐ Procedure reports

I understand I have the right to revoke this authorization at any time by submitting the request in writing to Advanced PainCare.

Patient Signature: _____ Date: _____/_____/_____

Print Name: _____ Date of Birth: _____/_____/_____

Effective Date: _____/_____/_____

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Office Hours: Monday through Thursday
8:00 am to 5:00 pm
CLOSED ON FRIDAY

PHONE SYSTEM MESSAGING

In an effort to provide a high standard of care and service to our patients
we are currently using a patient call phone messaging system.
When you call **Advanced PainCare at 932-0606**
you will hear the following greeting:

Thank you for calling Advanced PainCare, the office of Dr. Michael Fishell.

Please listen carefully to the following options:

- If this is a medical emergency, please hang up and dial 911.
- If you know your parties extension, please dial it now.
- To better serve you, please choose from the following options:
  - · If you have recently had a procedure and have a question regarding that procedure Press 1
  - · If you are a new patient calling to schedule an appointment Press 2
  - · For medical assistant messaging including medication refill request Press 3
  - · For procedure scheduling Press 4
  - · For billing questions Press 5
  - · For medical records Press 6
  - · All other calls Press 0

Timely response will best be obtained by
leaving a message on the appropriate extension.
Please leave only one message with your name, best number to reach you at and a brief message.
Duplicate messages only encumber the system and take valuable time
that could be better used in our follow up response.
We thank you in advance for your cooperation in participating in our phone messaging procedure
to provide a high standard of care and service to you.

ANSWERING SERVICE

After hours, Fridays, weekends, holidays
answering service WILL NOT TAKE GENERAL MESSAGES.
This service is only for those who recently had a procedure and
have a question regarding that procedure.

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name _____ Date _____/_____/_____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, may individual rights and the practices legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected Health Information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use of disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.

  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.

  - The right to receive confidential communications of protected health information.

  - The right to inspect and copy protected health information.

  - The right to amend protected health information.

  - The right to receive an accounting of disclosures of protected health information.

  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices' current Notice of Privacy Practices on request.

Signature: _____ Date: _____/_____/_____

Relationship to patient (if signed by a personal representative of the patient) _____

Advanced PainCare

Michael Fishell, M.D.
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Privacy Officer: Practice Manager

Effective Date: MARCH 1, 2003

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is requred to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. Al subsidiaries, business associated (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

(over)

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at ths practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice with the effective date in the upper right corner of the first page.

Advanced PainCare

PERSONAL INJURY INTAKE FORM

NAME: _____ AGE: _____ DATE: _____

- OFFICE USE -

BP: _____

HR: _____

HT: _____

WT:_____

COLLISION INFORMATION:

Date of Collision: ___/___/___ **Time of Collision:** _____

Your Vehicle: Year _____ Make _____ Model _____

Collision Type: ☐Rear Ended ☐Head-on ☐Broad-sided ☐Side swiped

Other Vehicle: Year _____ Make _____ Model _____

Were you the: ☐Driver ☐Passenger

If passenger, where were you sitting:☐Front Seat☐Back Seat☐Right Side☐Left Side

Were you wearing your seatbelt: ☐Yes ☐No

Did the airbag deploy: ☐Yes ☐No

Impending Collision, were you: ☐Aware ☐Unaware

Head position: ☐Straight ahead ☐turned left ☐turned right ☐bent down ☐bent back

Torso position: ☐Straight ahead ☐turned left ☐turned right ☐bent down ☐bent back

Did any part of your body strike anything inside of your car: ☐Yes ☐No

(If Yes) What Body Part: _____ What area of the car: _____

Did you experience: ☐Shock ☐Loss of Consciousness

Describe Collision: _____

_____

_____

_____

_____

_____

_____

Draw a picture / Diagram of collision:

LAW ENFORCEMENT

FOLLOWING THE COLLISION: (Mark a ✓ on each that applies)

☐**Police were called** ☐**Hit & Run** *(no information to exchange)*

☐**I have copy of the police report** **Officer's name:** _____

☐**I was ticketed**

MEDICAL HELP

FOLLOWING THE COLLISION: (Mark a ✓ on each that applies)

- ☐ **Ambulance / Paramedics were called**
- ☐ **I was treated at the scene**
- ☐ **I was transported to Hospital by Ambulance**
- ☐ **I went to the Hospital** ☐ **on my own** ☐ **via friend** ☐ **via family: When?** _____
- ☐ **X-rays/MRI were done at Hospital: What body area:** _____
- ☐ **Medication was prescribed by the Hospital: What:** _____

DOCTORS SEEN FOR THIS COLLISION:

Clinic name Practitioner's Name Approximate Date(s) seen

_____

_____

_____

_____

_____

_____

_____

PRE-EXISTING:

Have you been involved in previous personal injury cases: ☐ Yes ☐ No

(If Yes) Date (approximate) Type of Injury

_____ _____

_____ _____

_____ _____

_____ _____

Were there any injuries/symptoms which had not resolved prior to this injury event: ☐ Yes ☐ No

(If Yes) Injury/Symptom On Going Treatment

_____

_____

_____

_____

Prior to this injury have you ever needed to be treated for a painful injury/condition: ☐ Yes ☐ No

(If Yes) Injury/Condition Treatment

_____

_____

_____

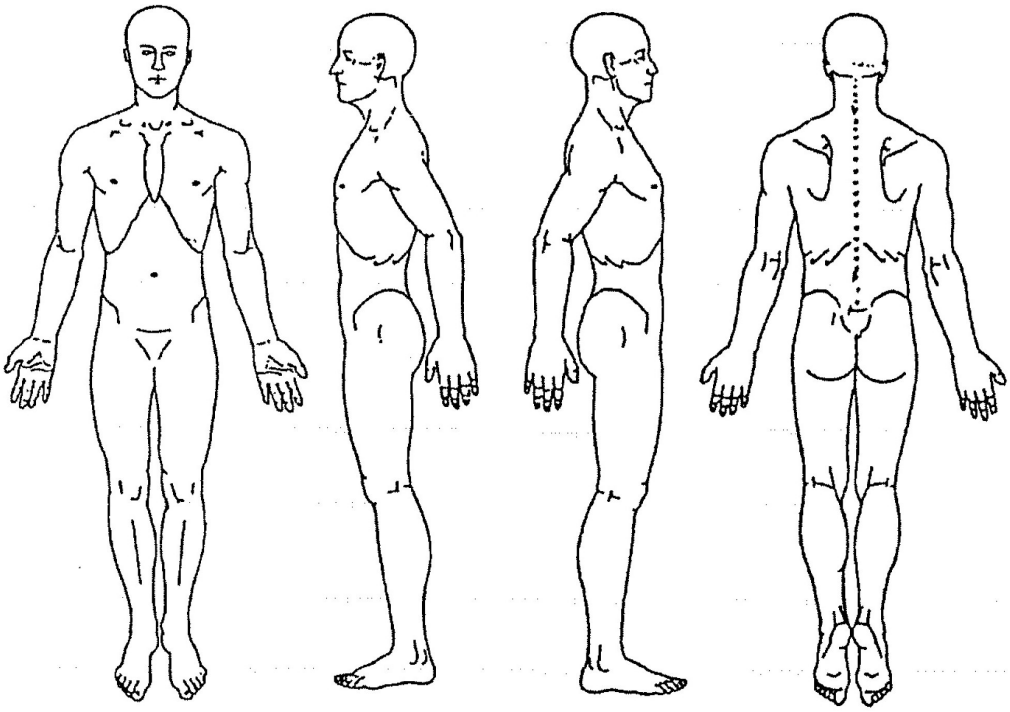
_____

SYMPTOMATOLOGY:

FROM THIS COLLISION: (Pain characteristics for MAJOR area(s) of complaint)

Use the descriptions below to mark the areas in which you feel these sensations:

Stabbing: S **Numbness**: N **Tingling**: T **Burning**: B **Dull**: D **Achy**: A **Cramping**: C **Pin/Needles**: P



FRONT **LEFT** **RIGHT** **BACK**

MUSCLE - SKELETAL:

Mark a ✓ on symptoms that have resulted **DUE TO THIS COLLISION**

Mark a **X** on symptoms that you had **PRIOR** but made **WORSE DUE TO THIS COLLISION**

☐ Headaches/Migraines	☐ Neck Pain	☐ Along Shoulder Blades
☐ Numbness in Arms/Hands	☐ Mid-Back Pain	☐ Chest Pain
☐ Low Back Pain	☐ Leg/ Calf Pains	☐ Numbness in Legs/ Feet

Rate your pain on a scale of 0-10. "0" is no pain at all, "10" is the worst pain you can imagine:

Now:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
At its worst:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
At its best:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Average:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Cognitive / Emotional / Sensory:

Mark a ✓ on symptoms that have resulted **DUE TO THIS COLLISION**

Mark a **X** on symptoms that you had **PRIOR** but made **WORSE DUE TO THIS COLLISION**

☐ Ringing in Ear	☐ Vertigo/ Dizziness	☐ Difficulty Concentrating	☐ Irritability
☐ Sensitivity to Light	☐ Highly Emotional	☐ Thoughts of Suicide	☐ Fatigued
☐ Night mares	☐ Loss of Libido	☐ Loss of memory	☐ Anxiety
☐ Loss of Balance	☐ Sensitivity to Sound	☐ Sensitivity Hot / Cold	☐ Depression

SELF-CARE:

What do you do for yourself to relieve any the symptoms?

Take Non-Prescription Medications

Medication name _____ Dosage _____ Frequency _____

_____

_____

_____

Take prescription Medications

Medication name _____ Dosage _____ Frequency _____

_____

_____

_____

☐ Use ice / heat
☐ Get extra Rest / sleep
☐ Do Stretches / Exercise
☐ Massage

EFFECTS OF YOUR INJURIES / SYMPTOMS:

Please Mark a ✓ on each that applies to your activities affected by injuries due to this collision:

☐ Have to hold onto something to sit or stand from a chair.
☐ Stay at home most of the time.
☐ Have to sit most of the day.
☐ Stays in bed most of the day.
☐ Change position frequently to try and get comfortable.
☐ Have difficulty turning over in bed.
☐ Have to lie down and rest frequently.
☐ Have to get other people to do things for me.

EMPLOYMENT HISTORY / CHANGE:

WERE YOU EMPLOYED AT THE TIME OF THE COLLISION?: ☐ Yes ☐ No

Your job Duties: _____

_____

DID YOU LOSE YOUR JOB DUE TO THIS COLLISION?: ☐ Yes ☐ No

PRIOR MEDICAL HISTORY:

WHAT ARE YOUR PAST OR CURRENT MEDICAL PROBLEMS *(check all that apply)***:**

- ☐ Heart disease ***Explain***: _____
- ☐ Stroke ***Explain***: _____
- ☐ Autoimmune disorder ***Explain***: _____
- ☐ Bleeding disorder ***Explain***: _____
- ☐ Lung disease ***Explain***: _____
- ☐ Neurological disease ***Explain***: _____
- ☐ Mental/nervous disorder ***Explain***: _____
- ☐ Tumor or cancer ***Explain***: _____
- ☐ Liver disease ***Explain***: _____
- ☐ Peripheral artery disease (PAD/PVOD) ***Explain***: _____
- ☐ Other: _____
- ☐ High blood pressure
- ☐ Bladder/kidney disease
- ☐ Seizures
- ☐ Peptic ulcer disease
- ☐ Thyroid/endocrine Problem
- ☐ Diabetes

Do you smoke: ☐Yes ☐No

Do you take blood thinning medications: ☐Yes ☐No

Do you have a pacemaker: ☐Yes ☐No Company: _____ ☐Defibrillator ☐Non-Defibrillator

WHAT MEDICATIONS ARE YOU ALERGIC TO:

Medication name _____ Reaction _____

_____

_____

_____

WHAT PRESCRIPTION MEDICATIONS DO YOU TAKE:

Medication name _____ Dosage _____ Frequency _____

_____

_____

_____

WHAT PREVIOUS SURGICAL PROCEDURES HAVE YOU HAD:

Surgery _____ Date _____

_____

_____

_____

I verify I have reviewed all pages of this Personal Injury Intake form and the information I have provided is to the best of my abilities factual / accurate.

Print Name: _____

Patient Signature: _____ **Date:** _____/_____/_____