Welcome to Comprehensive Physician Services!

We are a multi-disciplinary practice that *specializes* in the care of injury victims. Our Chiropractors, Medical Doctors, Nurses/CMA's and Massage Therapists unite in rehabilitating our patients to maximum medical improvement. We will anticipate our patients' needs and we are committed to providing a wide variety of treatment to benefit all types of injuries.

You have taken the first step in your rehabilitation by choosing our practice to tend to your needs. Each patient is equally important to us so in an attempt to form a long-term relationship with you, here are a few things that will help guide you through your treatment.

Patient Advocate- Kendall Trosky 813-690-8844

This is your patient advocate and attorney liaison. She is available to answer all of your questions in regards to your care. Many patients find it necessary to seek legal representation and with 15 years experience in this field, Kendall has the resources to provide you with many choices.

SIGNING IN

When you arrive, sign in. You will be called back in the order of your appointment time. Other patients being treated by another doctor may be called before you because their doctor is available, not because they are taken out of turn.

HOURS

The office and doctors have specific office hours. The Medical office staff will schedule your appointments accordingly. If you have a special request for an appointment time, speak with the office staff and we will accommodate your needs if possible.

MISSING OR CHANGING APPOINTMENTS

Each patient is evaluated and given a specific course of treatment that will most benefit your injuries. A certain number of treatments are required in a specific amount of time for us to get the results we both desire. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week. Please be responsible and call our staff if you cannot make an appointment or you are going to be late for your appointment. If you are late for an appointment and have not called, you may be asked to wait until we have an opening.

OFFICE POLICY

Regardless of who the responsible party is, a claim will be established with your insurance company by Florida Law. Contact your agent and inform them of your care in this office and have all forms sent directly to us. It is your responsibility to supply us with the coverage information of the vehicle you were in at the time of the accident. If you are making a claim against the liability policy of another vehicle and an attorney represents you. We will send a copy of the bills and records to your attorney.

You are personally responsible for the bill, but you will not be required to pay at the time of service as long as we are billing your insurance company and/or attorney and the necessary lien forms have been signed by you, ensuring that we will be paid at the time of the settlement of your case. This is done as a convenience to you.

DRUG POLICY

*Any medications prescribed by the doctor today are to be taken as prescribed. We are **UNABLE** to refill prescriptions sooner than the **appropriate date**.

*If a prescription is prescribed to you by one of our doctors and you find that it is not working, you **MAY** be asked to bring in the **UNUSED PORTION** of the medication into our office before a different medication is prescribed to you. Without this, a new medication **MAY NOT** be prescribed.

*If your prescription is stolen and a new prescription is requested from one of our doctors, you **MUST** present to our office a copy of a police report **BEFORE** we are able to issue a new prescription. Without the report, our office **WILL NOT** write a script until the appropriate date.

*No medication (new or refill) can be given at night or on weekends. Medication can only be ordered by your doctor during regular business hours when your chart can be accessed.

*If in the event you are referred to Pain Management, prescriptions will **NO LONGER** be given by our office. They **MUST** be obtained from the Pain Management office.

Comprehensive Physician Services, Inc.

Patient Intake Form

Office: Tampa ___ St Pete ___ Riverview ____ Lakeland____ Temple Terrace____ Largo____
New Port Richey ____ Palm Harbor _____ Plant City_____

Patient Name: _____ Soc Sec #: _____

Office use only
___MVA ___S/F ___W/C ___PI ___Other / Driver ___ Passenger___ Pedestrian___
___Motorcycle ___Bicycle If passenger, did the vehicle belong to: Patient___ Other ___
Date: ___/___ /___ Date of **injury**: ___/___/___ Was accident work related: Yes__No__

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell phone: _____

Age: _____ Date of Birth: ___/___/___ Sex: M___ F ___

State accident occurred:_____ Marital Status: M S D W

Are you currently under a doctor's care for this injury? Yes ___ No ___

If yes, please list facility / Doctor and phone number:
_____
_____
_____

Did you have **X-rays**? Yes___ No ___ **MRI's**? Yes___ No ___ **CT's**? Yes___ No ___

Primary care physician: _____ Phone: _____

Attorney Name: _____ **Phone:** _____

Attorney Address: _____

City: _____ **State:** _____ **Zip:** _____

Please have your driver's license, Auto Insurance card, Health Insurance Card and Accident Report available for copy. Thank You.

Office use only
LOP requested: Yes ___ No ___ , Date: _____ Received: _____
AOB Sent: Yes ___ No ___, Date: _____
Letter of intent to bill sent: Yes ___ No ___ , Date: _____ Received: _____

Comprehensive Physician Services, Inc.

2604 W. Waters Ave
Tampa, Fl 33614
(813)879-6200 Fax (813)876-9243

Office: Tampa ___ St Pete ___ Riverview ____ Lakeland____ Temple Terrace____ Largo____
New Port Richey ____ Palm Harbor ____ Plant City ____

Patient Name: _____
Address: _____
City: _____ Stet: _____ Zip: _____
DOI: _____ Claim #_____

ASSIGNMENT OF BENEFITS/POLICY RIGHTS/DIRECT PAYMENT AUTHORIZATION

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to Comprehensive Physician Services, Inc. ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient for it's failure to pay for services rendered unto me by assignee in relation to any accident or illness. This assignment may only be rescinded/reassigned by the mutual consent of the patient/insured/assignor and health care provider/assignee.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of any benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

DIRECTION OF PAYMENT/RELEASE OF INFORMATION

I hereby authorize any insurance company or attorney to pay direct to Assignee the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, I hereby request a copy of the PIP payment log and any available policy of Insurance or declaration sheet, to be provided by the insurance company to the Assignee. I hereby authorize Assignee permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

_____ _____
Patient's signature or patient/guardian Date

Application For Benefits – Personal Injury Protection

(To enable us to determine if you are entitled to benefits under the personal injury protection law, please complete this form.)

Date_____Our Policy Holder_____DOI_____CL#_____

Your Name_____DOB_____Home#_____

Your Address_____Bus.#_____

Date and Time of Acc._____Place of Acc._____SS#_____
Brief Description of Acc.

At time of Accident: Were you the driver of the policyholder's car? Yes__ No__ Were you the passenger in the policyholder's car? Yes__ No__ Were you a pedestrian? Yes__ No__

Are you a member of our policyholder's household's household? Yes__ No__ Relationship to policyholder_____
As a result of the accident, were you injured? Yes__ No__ If your answer is yes, please complete the rest of this form. If No, Sign here and return the form to us.
Signature:

Describe your injury:

Were you treated by a doctor: Yes__ No__ Date of first treatment_____If you were treated in the hospital: Inpatient___ Outpatient___
Doctor's name and address:

Hospitals name and address:

Amount of bills to date_____ Will you have more medical expenses? Yes__ No__ Were you employed at time of accident? Yes__ No__
Did you lose time from work? Yes__ No__ If yes. Amount lost: $_____Average weekly wage or salary:$_____
If you lost time: Date disability began___/___/___ Date you returned to work___/___/___

Have you received or are you eligible for benefits under:
1) Workman's Compensation Law? Yes__ No__ If yes, amount: $_____
2) Employment by U.S. Government? Yes__ No__ ___ per week ___ per month
3) Military? Yes__ No__

List name and addresses of your employers at the date of the accident and give occupation and dates of employment

Employer address_____Occupation _____From _____ To_____

Employer address_____Occupation _____From _____ To_____

Any person filing a statement of claim containing any false, incomplete of misleading information is guilty of a felony of the third degree. I declare that the facts shown hereon are true and complete to the best of my knowledge and that no attempt has been made to conceal facts or to deceive any insurance company.

Signature_____ Date _____/_____/_____

Comprehensive Physician Services, Inc.

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Office: Tampa ___ St Pete ___ Riverview ____ Lakeland____ Temple Terrace____ Largo____
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Patient Name: _____

Authorization to obtain PIP Payouts / Payment EOB's

Request under section S.627.736(7)

Policy# _____

Claim# _____

I, _____ authorize my PIP Insurance carrier to immediately provide a PIP Payout explanation to **Comprehensive Physician Services, Inc.** I also authorize an Explanation Of Benefits (EOB) be included with each payment to this physicians office.

_____
Patient's signature

_____
Date

Patient's Assignment of Benefits is attached

Comprehensive Physician Services, Inc.

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Office: Tampa ___ St Pete ___ Riverview ____ Lakeland____ Temple Terrace____ Largo____
New Port Richey ____ Palm Harbor ____ Plant City ____

Patient Name: _____

IRREVOCABLE DOCTOR'S LIEN

Attorney Name & Address: _____
_____
_____

I do hereby authorize Comprehensive Physician Services, Inc, to furnish you, my attorney with a full report of my case history, examination, diagnosis, treatment, and prognosis in regard to my accident/illness which occurred/began on _____.

I hereby authorize and irrevocably direct you my attorney, to pay directly to COMPREHENSIVE PHYSICIAN SERVICES, INC., sums due and owed for professional services rendered both by reason of this accident and any other bills that are due this office and to be necessary adequately to protect Comprehensive Physician Services, Inc. I hereby further give a settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Comprehensive Physician Services, Inc. for all professional bills, submitted by them for services rendered me, and that this agreement is made solely for said facility's additional protection and in consideration of payment. I further understand that such payment is not contingent on any recover said fee.

_____ _____
Patient/client signature Date

I have been advised that if my attorney does not cooperate, Comprehensive Physician Services, Inc. will not await payment, but may declare the entire balance due and payable.

The undersigned being the attorney of record for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such sums from settlement, judgment, or verdict as may be necessary to protect adequately Comprehensive Physician Services, Inc.

_____ _____
Attorney's signature Date

Comprehensive Physician Services, Inc.

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Patient Name: _____

AUTHORIZATION TO PROVIDE A LETTER OF PROTECTION

Comprehensive Physician Services, Inc. has requested a Letter of Protection for any balance that is due this doctor or facility at the time that my case is settled or otherwise disposed of. The balance due will be deducted from the proceeds of such settlement, subsequent to the deduction of attorneys' fees and cost. Of course, in the event no recovery is obtained, I shall remain responsible for the payment of this account.

I do authorize my attorney to provide the above mentioned a Letter Of Protection.

_____ _____
Patient/client signature Date

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Office: Tampa ___ St Pete ___ Riverview ____ Lakeland____ Temple Terrace____ Largo____
New Port Richey ____ Palm Harbor ____ Plant City ____

Patient Name: _____

Benefit Assignment to Patient

I, _____ am seeking medical treatment for injuries sustained in a motor vehicle accident on, _____ / _____ / _____.

I **do not** have PIP insurance of my own. Mr. / Ms. _____ has motor vehicle insurance with _____, Policy #_____, Claim#_____, which I meet the state required qualifications, S.627.733 to be covered by this policy.

_____ _____
Patient's signature Date

I, _____, the policy holder, do authorize the above named person to use my vehicle insurance for filing medical claims for the above mentioned motor vehicle accident,
Policy# _____,
Claim# _____.

_____ _____
Policy Holder's signature Date

Comprehensive Physician Services, Inc.

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Office: Tampa ___ St Pete ___ Riverview ____ Lakeland____ Temple Terrace____ Largo____
New Port Richey ____ Palm Harbor ____ Plant City ____

Explanation of Financial Responsibility, according to Florida PIP Laws

1) If you have a policy with a deductible:

You, the patient, are responsible to pay your deductible.

Should you have an attorney to represent you with your case the deductible share will be part of the settlement at the end of your case, providing your lawyer issues us a Letter of Protection.

2) If you have chosen a policy that pays a percentage of the medical charges:

You, the patient, are responsible to pay the percentage not paid by your insurance.

Should you have an attorney to represent you with your case the percentage share will be part of the settlement at the end of your case.

3) Should you not be represented by an attorney and are faced with financial hardship please notify a staff member.

I have read and understand the above information

_____ _____

Patient's signature **Date**

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New Port Richey ____ Palm Harbor ____ Plant City ____

STANDARD AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used or disclosed:

Patient Name: _____
Date of birth: _____ / _____ / _____
Social Security # _____ - _____ - _____

Description of information to be used/disclosed _____
(visit dates, types and reports) _____

Name of person or Organization _____
(name of facility or hospital disclosing information)

Persons to whom information may be disclosed _____
(name of person or organization)

Reason for request _____
(i.e. legal, continue medical care, personal, etc)

Expiration date of Authorization:
This authorization is effective through ___ /___/ ___ unless revoked or terminated by the patient or the patient's personal representative.

Right to terminate or revoke Assignment:
You may revoke or terminate this authorization by submitting a written revocation to Comprehensive Physician Services, Inc.

You have a right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under Federal Privacy Regulation.

_____ _____
Patient's signature Date

_____ _____
Patient Representative's signature Relationship of Patient Representative to patient

HIPAA Notice of Privacy Practices

Comprehensive Physician Services, Inc

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY NE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, or office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.,

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health pan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as- needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example we may disclose your protected health information to medical school students that see patients at our offices. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section164.500.

Other permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken as action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

Your have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restriction requested an to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have a right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terns of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April14, 2003.**

_____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices: Date:_____

Print Name: _____ Signature: _____

Compliance assurance notification for our patients

Comprehensive Physician Services, Inc

To our valued patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and loss of money. We want you to know that all of our employees, managers and doctors continually undergo training so that they can understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Patient Consent Form

The Department of Health Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We would like to inform you that some of the treatment may be performed in an open-air environment and if you prefer a more private setting please inform us and we will do everything to accommodate your wishes.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relations with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. In addition, we would like you to know, we do not release or sell information to telemarketer, mailing houses or commerce internet marketers.

You may refuse to consent to the use or disclosure of your personal health information, but must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer.

You have the right to review our privacy notice. By your signature below you acknowledge receipt in the form of a copy of the Compliance Assurance Notification and acceptance of this privacy policy.

Print Name: _____

Signature:_____Date:_____

Comprehensive Physician Services, Inc.

Patient History Checklist

Office: Tampa ___ St. Pete ___ Riverview___ Lakeland ___ Temple Terrace___ Largo ___ New Port Richey___
Palm Harbor ___ Plant City ___

Patient Name:_____ Date:_____

Height:_____ Weight:_____ Age:_____

Left or Right handed: Left_____ Right_____ Date of accident: ____/____/____

Vehicle information: Car___ Truck ___ SUV ___ Motorcycle ___ Bus ___ Bike ___
Where was the vehicle hit? Front ___ Rear___ Right side___ Left side___
Were you the? Driver___ Passenger___ Pedestrian___ Bike___ Motorcycle___
Were seat belt restraints used? Yes ___ No ___

Please answer the following questions as it relates to your condition AFTER the accident:
Circle yes or no and explain if yes.

Head:

1. Do your recall hitting your head during impact?		Y / N	Explain: _____
2. Do you have headaches?		Y / N	Explain: _____
3. In what area do you feel the headache?			_____
4. Were you dazed?		Y / N	Explain: _____
5. Did you lose consciousness?		Y / N	Explain: _____
6. What is the 1st thing you remember after impact?			_____
7. Did you see a bright flash of light?		Y / N	Explain: _____
8. Have you seen?	Floating spots:	Y / N	Explain: _____
	Sparkling dots:	Y / N	Explain: _____
9. Any:Dizziness?		Y / N	Explain: _____
10.Any:Blurry Vision?		Y / N	Explain: _____
11.Any:Nausea/Vomiting?		Y / N	Explain: _____
12.Do you notice a head rush/light headedness when you stand up?		Y / N	Explain: _____
13.Does your head or face have?	Numbness?	Y / N	Explain: _____
	Tingling?	Y / N	Explain: _____
	Stinging?	Y / N	Explain: _____
14. Any ringing in your ears?		Y / N	Explain: _____
15. When you open your jaw do you have?	Clicking?	Y / N	Explain: _____
	Popping?	Y / N	Explain: _____

Cranial Nerves:

1. When you have headaches do you have pain behind your eyes?	Y / N	Explain: _____
2. When you have headaches do you have sensitivity to light?	Y / N	Explain: _____
3. Any:Loss of normal vision?	Y / N	Explain: _____
4. Any: Loss of ability to move both eyes w/o a problem?	Y / N	Explain: _____
5. Any problem winking eyes or closing them?	Y / N	Explain: _____
6. Any:Loss of ability to taste? Y / N *Trouble moving your tongue?	Y / N	Explain: _____
7. Any loss of ability to hear?	Y / N	Explain: _____
8. Any difficulty Swallowing Y / N *Pain when swallowing:	Y / N	Explain: _____
9. Any Hoarseness in your voice?	Y / N	Explain: _____
10. Any trouble shrugging your shoulders? Rt / Lft?	Y / N	Explain: _____
11. Any trouble smiling?	Y / N	Explain: _____

Medical History Since the Accident

1. Difficulty sleeping due to pain?	Yes___	No___
2. Trouble with memory?	Yes___	No___
3. Mood swings since accident?	Yes___	No___
4. Feel depressed?	Yes___	No___
5. Feel tired or fatigued?	Yes___	No___
6. Any sexual problems?	Yes___	No___

7. Are you employed, retired, disabled, student or minor?_____
8. Were you out of work due to this accident? Yes___ No___ How long?_____
9. What type of work do you do?_____(computer,long sitting, standing, bending. Etc)

Patient Signature: _____

Dr. Initials _____

Updated 10/20/2009

Past Medical History

Patient Name: _____

Do you have or have you been treated for any of the following: Circle yes or no

asthma	Y / N	heart disease	Y / N	high blood pressure	Y / N	gastritis/ulcers	Y / N
fibromyalgia	Y / N	stroke	Y / N	osteoporosis	Y / N	low/high thyroid	Y / N
liver disease	Y / N	depression	Y / N	immunodeficiency	Y / N	kidney disease	Y / N
diabetes	Y / N	seizures	Y / N	bleeding disorder	Y / N	cataracts	Y / N
cancer (type)_____			Y / N	hepatitis(type)_____	Y / N	glaucoma	Y / N
HIV/AIDS (precautionary measures)			Y / N	Contagious Skin Disorder	Y / N		

Please list any health problems not listed above:_____

Hospitalization (include this accident)/Operations/Previous Auto Accidents

Date	Incident	Reason/Procedure	Hospital

Current Medication (please include any vitamins or herbal medications)

Name	Dose	Frequency

Medication Allergies

List any medication allergies and the type of reaction: (if none are known check here___)

_____

Family History: please check all that apply to your family members (M / Mother, F / Father)

allergy	___M ___F	N/A____	high blood pressure	___M ___F	N/A____
osteoporosis	___M ___F	N/A____	kidney disease	___M ___F	N/A____
seizures	___M ___F	N/A____	stroke	___M ___F	N/A____
cancer	___M ___F	N/A____	depression	___M ___F	N/A____
diabetes	___M ___F	N/A____	seizures	___M ___F	N/A____
heart disease	___M ___F	N/A____	other		

Social History

1. Do you presently smoke?	Yes___No___	# packs/day ___	# yrs___
2. Have you ever smoked?	Yes___No___	# packs/day ___	# yrs___
3. Do you drink alcohol?	Yes___No___	# drinks/day ___	
4. Have you ever used any addictive substances?		Yes___(substance:_____)No___	

Review of systems: please circle yes or no. If yes, please explain.

1. **Ears**: ringing/dizziness/drainage/hearing loss	Y / N	Explain: _____
2. **Mouth/throat**:pain or difficulty swallowing/hoarseness/lumps in neck	Y / N	Explain: _____
3. **Cardiopulmonary**:chest pain/palpitations/short of breath/heart murmur/cough	Y / N	Explain: _____
4. **Genitourinary**:burning or frequency of urination	Y / N	Explain: _____
5. **Gastrointestinal**:heartburn/vomiting/diarrhea/abdominal pain	Y / N	Explain: _____
6. **Psychological**:depression	Y / N	Explain: _____
7. **Sleep pattern**: Snoring/Daytime sleepiness	Y / N	Explain: _____
8. **Endocrine**:Heat Intolerance/Cold intolerance/Excessive thirst	Y / N	Explain: _____
9. **Eyes**: recent changes in vision/Impaired vision/Double vision	Y / N	Explain: _____
10.**Neurologic**:weakness/numbness	Y / N	Explain: _____
11.**Musculoskeletal**:TMJ disorder/Arthritis	Y / N	Explain: _____
12.**General**:nausea/fever/fatigue/weight gain	Y / N	Explain: _____
13.**Skin**:Skin cancer	Y / N	Explain: _____
14.**Hematologic/Lymphatic**:Swollen lymph nodes	Y / N	Explain: _____
15.**Immunologic**:Hepatitis/Frequesnt Infections/Immune Disorders	Y / N	Explain: _____
16.**Constitution**: Sudden weight loss or gain?	Y / N	Explain: _____

16.Are you pregnant? Yes___No___ How many months?_____

17.Are you breast feeding? Yes___No___

Patient Signature:_____

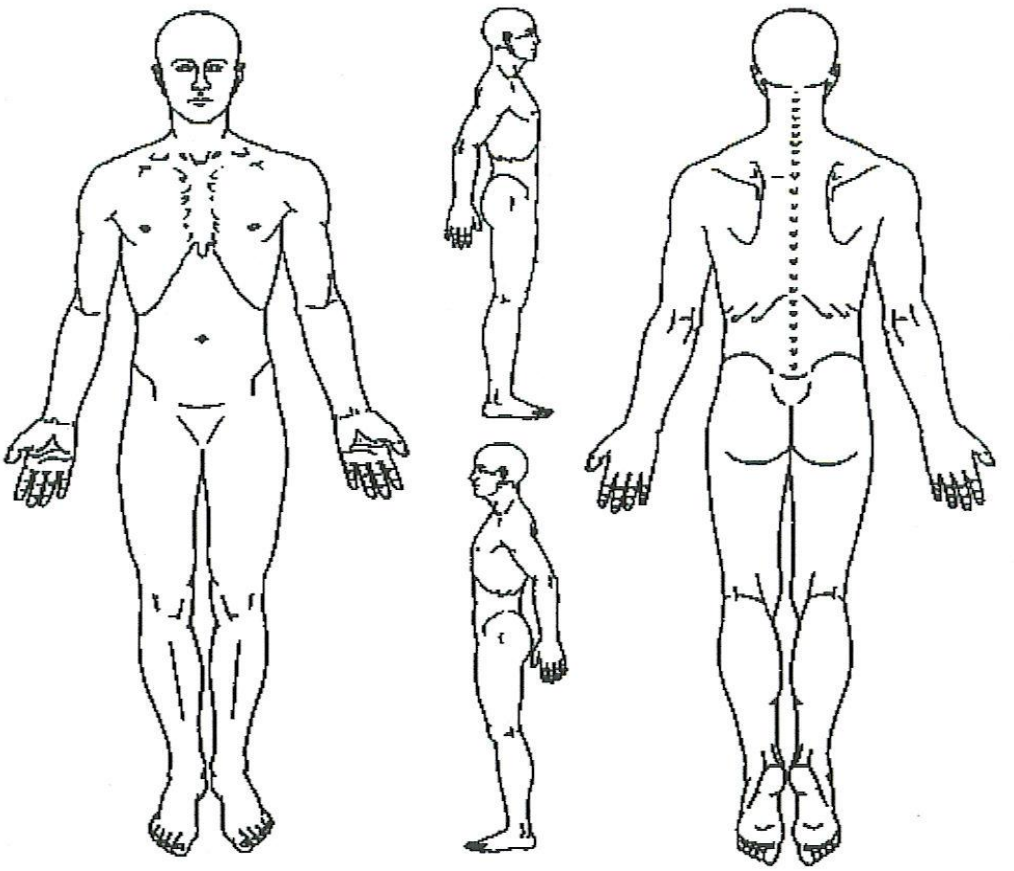
Dr. Initials _____

Updated 2/20/2009

PAIN DIAGRAM

NAME _____ DATE _____

On the diagram below, please indicate where you are experiencing pain other symptoms, right now.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

I certified that I have read and understand all of the information requested of me concerning my medica history and health problems, and that my answers are true and accurate to the best of my knowledge. I further certify that I do have the indicated health problem(s) and that I desire an appropriate medical examination, treatment and/or advice necessary.

Date_____ Print Name_____

Patient Signature_____

Attending Doctor: I have personally reviewed the history and review of systems:

Date_____ Doctor's Signature:_____

Dr. Initials _____

Updated 2/20/2009