Physicians Plus Spine & Rehab Center
1106 Pulaski Highway
Bear, Delaware 19701
Tel. 302-300-1111

Sean P. Feeney, M.S., D.C., CMUA
Specializing in Auto & Work Related Injuries

Personal Injury (non-auto) Patient Information

Name:_____ **Date:**_____ **File #**
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
DOB:_____ **Age** _____ **Social Security** _____
Home #:_____ **Work #:**_____ **Cell #:**_____ **E-mail:**_____

Primary Care Physician:_____
Referred to United Spine Centre:_____

Date of Injury:_____ **Time:** _____

Name of Insurance Company Responsible for the Payment of Your Injuries:_____
Address: _____ **City:**_____ **State:**_____**Zip:**_____
Claim#:_____**Claim Agent:** _____ **Ph#**_____

Very Important (for your protection)
❑ Yes ❑ No
I have completed and turned in all of the paperwork, forms, etc. required by the Insurance Company in order to initiate payment on my medical bills. You should be fully aware that it is your responsibility to complete the necessary paperwork as mandated by the Insurance Carrier that is responsible for the payment of all medical expenses that you may have already accrued from other treatment(s) or shall accrue from this or any subsequent treatment(s).
If this paperwork is not completed (in a timely manner) the Insurance Company will not initiate the payment of your benefits and may choose to deny payment on your entire claim, regardless of the party at fault.
We are here to help you simplify this process by answering any questions to the best of our ability. Please do not hesitate to ask for assistance.

❒ Yes ❒ No Do you have any Private Health Insurance? (This is for your protection in case of the denial of your claim.)

Name of Private Insurance:_____
ID#: _____
* Please Note, this information is for your protection in case there is an emergency
* Please provide a copy of your private insurance card

❒ Yes ❒ No Do you have an attorney to assist you?
If yes, Law Firm:_____
Attorney:_____
Address: _____**City:**_____
State:_____ **Zip:**_____

Location of injury (Town, State):_____
Where (restaurant , store, home, sidewalk)?: _____
_____
_____

❒ Yes ❒ No This injury occurred on my free time and I was not working for my employer.
** NOTE – If your injury occurred as a result of your employment, please stop with this form and discuss with the front desk.*

❒ Yes ❒ No Do you feel that there was any negligence that attributed to your injury?

❒ Yes ❒ No Did you report this injury? If so, to whom?
Name:_____
Telephone#:_____
Title:_____

How would you best describe your condition after the injury? (check all that apply):
❒ Shaken up, but functional ❒ Dazed and confused
❒ Circumstances vague ❒ Loss of consciousness

Briefly list your symptoms immediately after the injury:_____
_____
_____

❒ Yes ❒ No Have your symptoms changed since your injury?
❒ Yes ❒ No Did you suffer any cuts, lacerations or bruises? If yes, please describe_____
_____
❒ Yes ❒ No Did you suffer fractures (broken bones)? If yes, please describe_____
_____

Immediate Treatment

❒ Yes ❒ No Were you taken to the Emergency Room immediately after the injury? (If yes, how were you transported) ❒ Ambulance ❒Drove Self ❒ Driven by another ❒ Medi-Vac

❒ Yes ❒ No Did you go to the Emergency Room later in the day or at all? If you went to the Emergency Room, which one? _____
If you went to the Emergency Room, did you (check all that apply)
❒ get examined ❒ have x-rays ❒ have a Cat Scan
❒ get stitches ❒ have an EKG ❒ get admitted to the hospital
❒ Others_____

❒ Yes ❒ No Were you prescribed any medications? If yes, what medications?_____
_____

Follow-up Treatment

❒ Yes ❒ No Did your condition worsen compared to how it was immediately after this injury.

❒ Yes ❒ No Have you seen your family physician? If yes, what medications/treatments were prescribed?___ _____

❒ Yes ❒ No Have you been to physical therapy?
If yes, where?_____
For how long?_____
Approximate times per week?_____

❒ Yes ❒ No Have you been referred to any specialist (i.e. Neurosurgeon, Neurologist, Orthopedic Surgeon, Physiatrist, etc.)
If yes, please list:
1. _____
2. _____
3. _____
4. _____

❒ Yes ❒ No Due to your injuries, have you had any of the following tests?

LOCATION

❒ X-Rays_____
❒ MRI_____
❒ Cat Scan_____
❒ EMG_____
❒ Other_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the Physicians Plus. I authorize physician to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. In the unanticipated event that the expenses for my treatment are not covered by my Insurance Carrier (or Private Insurance) I am responsible for payment of professional services.

I understand and agree to allow Physicians Plus to use my Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. I understand that my medical records are privileged and confidential information and that my records will be utilized by this office strictly within the parameters of my legal rights concerning said records.

I am aware that there is a more detailed account of all policies and procedures concerning the privacy of my Patient Health Information. We encourage you to read the HIPAA NOTICE that is available to you desk for you to read in its entirety at the front, before signing this notice. If there is anyone you do not want to receive your medical records, please inform our office.

_____ _____

Patient Signature **Date**

_____ _____

Guardian's Signature Authorizing Care **Date**

Present complaints due to the injury:

- ❒ Yes ❒ No Headaches
- ❒ Yes ❒ No Dizziness
- ❒ Yes ❒ No Light sensitivity
- ❒ Yes ❒ No Nausea with headaches
- ❒ Yes ❒ No Jaw pain
- ❒ Yes ❒ No Facial pain
- ❒ Yes ❒ No Heaviness of head
- ❒ Yes ❒ No Neck pain and/or stiffness
- ❒ Yes ❒ No Numb, tingling and/or weak down left arm
- ❒ Yes ❒ No Numb, tingling and/or weak down right arm
- ❒ Yes ❒ No Left shoulder pain
- ❒ Yes ❒ No Right shoulder pain
- ❒ Yes ❒ No Cramping of muscles in left arm
- ❒ Yes ❒ No Cramping of muscles of right arm
- ❒ Yes ❒ No Mid back pain and/or stiffness
- ❒ Yes ❒ No Pain into rib cage
- ❒ Yes ❒ No Sternal pain
- ❒ Yes ❒ No Low back pain and/or stiffness
- ❒ Yes ❒ No Numb, tingling and/or weak down left leg
- ❒ Yes ❒ No Numb, tingling and/or weak down right leg
- ❒ Yes ❒ No Cramp of muscles in left leg
- ❒ Yes ❒ No Cramping of muscles in right leg
- ❒ Yes ❒ No Left knee pain
- ❒ Yes ❒ No Right knee pain
- ❒ Yes ❒ No Left foot and/or ankle pain
- ❒ Yes ❒ No Right foot and/or ankle pain
- ❒ Yes ❒ No Anxiety
- ❒ Yes ❒ No Tension
- ❒ Yes ❒ No Insomnia
- ❒ Yes ❒ No Depression
- ❒ Yes ❒ No Difficulty with concentration
- ❒ Yes ❒ No Irritability
- ❒ Yes ❒ No Loss of taste
- ❒ Yes ❒ No Loss of smell
- ❒ Yes ❒ No Vision change
- ❒ Yes ❒ No Memory loss
- ❒ Yes ❒ No Fatigue
- ❒ Yes ❒ No Mental dullness
- ❒ Yes ❒ No Ringing or buzzing in ears

Notes:

_____

_____

_____

_____

_____

Present Medications

Injury Related	Prior to Injury

As a result of your injuries, are any of the following conditions difficult or impossible to perform? Check all that apply.

❒ Yes ❒ No ❒ Not Applicable Heavy lifting (50 lbs. and above from ground level)
❒ Yes ❒ No ❒ Not Applicable Moderate lifting (25 lbs. to 49 lbs. from ground level)
❒ Yes ❒ No ❒ Not Applicable Light lifting (Less than 25 lbs. from ground level)
❒ Yes ❒ No ❒ Not Applicable Bending
❒ Yes ❒ No ❒ Not Applicable Twisting
❒ Yes ❒ No ❒ Not Applicable Standing
❒ Yes ❒ No ❒ Not Applicable Sitting
❒ Yes ❒ No ❒ Not Applicable Sleeping
❒ Yes ❒ No ❒ Not Applicable Gripping
❒ Yes ❒ No ❒ Not Applicable Pushing
❒ Yes ❒ No ❒ Not Applicable Pulling
❒ Yes ❒ No ❒ Not Applicable Reaching
❒ Yes ❒ No ❒ Not Applicable Housework
❒ Yes ❒ No ❒ Not Applicable Dressing self (i.e. putting shoes on)
❒ Yes ❒ No ❒ Not Applicable Bathing/ Showering
❒ Yes ❒ No ❒ Not Applicable Brush teeth in morning
❒ Yes ❒ No ❒ Not Applicable Shaving
❒ Yes ❒ No ❒ Not Applicable Caring for children
❒ Yes ❒ No ❒ Not Applicable Sexual Activities

❒ Yes ❒ No Is there anything that makes you feel better? (i.e.: medication, exercise, heat/ice, rest)
(if yes , please explain) _____
_____

Past Medical History

❒ Yes ❒ No 1. Were any current complaints present prior to the injury?
(if yes, please explain)_____
_____
_____

❒ Yes ❒ No 2. Have there been any previous auto and/or work comp claim(s)? (if yes, please list all occurrences and approx. dates): _____
_____
_____

❒ Yes ❒ No 3. Have there ever been an impairment rating given or have they ever been listed with permanent injuries?

❒ Yes ❒ No 4. Have there been other major injuries in the past other than auto or work injuries?
(if yes, please explain) _____

Recreational Activities

List some of the hobbies or recreational activities you enjoyed prior to your injury. (i.e., hiking, dancing, playing with and/or lifting children, jogging, aerobics, working out, going out with friends, etc.).

1._____ 4._____

2._____ 5. _____

3._____ 6._____

Do you have, or have you had any of the following conditions?

❒ Yes ❒ No Allergies_____
❒ Yes ❒ No Anemia_____
❒ Yes ❒ No Asthma_____
❒ Yes ❒ No Back pain?
❒ Yes ❒ No Cancer_____
❒ Yes ❒ No Chronic Obstructive Pulmonary Disease_____
❒ Yes ❒ No Diabetes_____
❒ Yes ❒ No Depression/Anxiety_____
❒ Yes ❒ No Emphysema_____
❒ Yes ❒ No Gastrointestinal problems (i.e. Colitis, Chron's Disease)_____
❒ Yes ❒ No Headaches?
❒ Yes ❒ No Heart Disease_____
❒ Yes ❒ No Hepatitis / Cirrhosis_____
❒ Yes ❒ No High Blood Pressure_____
❒ Yes ❒ No High Cholesterol_____
❒ Yes ❒ No Headaches?
❒ Yes ❒ No HIV / AID's_____
❒ Yes ❒ No Stroke_____
❒ Yes ❒ No Thyroid Disease_____
❒ Yes ❒ No Ulcers (peptic or gastric)_____
❒ Yes ❒ No Other Medical Conditions (if yes, please describe): _____
_____

<u>Surgical History:</u> List surgeries (other than surgeries due to this injury) and approximate dates

1. _____
2. _____
3. _____
4. _____
5. _____

<u>Disability and/or Job Restrictions:</u>

❒ Yes ❒ No Has the injury resulted in any periods of total disability (i.e. not working at all)?
If yes, dates of disability: _____
If yes, what is the name of the Doctor who issued the disability?
_____

❒ Yes ❒ Have there been any job restrictions/limitations issued?
If yes, what is the name of the Doctor who issued the restrictions/limitations?
_____
If yes, what were the restrictions/limitations:_____
_____
_____

Social History

1. Martial Status: _____ Number of Children:_____

2. Education Status (check all that apply):
- ❒ Grade School
- ❒ High School
- ❒ GED
- ❒ Some College
- ❒ Associates Degree
- ❒ Specialty Degree (PTA, Dental Hygienist, Chiropractic Tech, MRI Tech)
- ❒ 4 Year Degree
- ❒ Graduate Degree
- ❒ Doctorate (PhD, EdD, etc)
- ❒ Professional Degree (MD, DO, DC, DDS, DVM, DPMETC)
- ❒ Professional Health Care Degree (RN, PT, ATC, PA, CNP, etc.)

Job Description and Work History

Employer: _____
Job Title: _____

❒ Yes ❒ No Does the job require lifting? If yes, what is the maximum amount you are required to lift? _____

Place a ✓ next to all that apply to the job requirements:

- ❒ Lifting (max weight)
- ❒ Bending
- ❒ Twisting
- ❒ Gripping
- ❒ Repetitive Use of arms
- ❒ Pushing
- ❒ Pulling
- ❒ Reaching
- ❒ Overhead Activity
- ❒ Repetitive use of legs

Others: _____

What are the average number of hours spent required to sit per day? _____
What are the average number of hours spent required to stand per day? _____
What are the average number of hours spent required to work per week? _____

❒ Yes ❒ No Tobacco use (smoking)? (if yes how much do you smoke) _____ packs per week.
❒ Yes ❒ No Tobacco use (chewing)? (if yes, On Rare Occasions _____ Moderate _____ Heavy _____).

❒ Yes ❒ No Alcohol Consumption?

a. Never _____
b. Very Rarely _____
c. Lightly_____ (average 1 drink or less per day)
d. Moderately _____ (average 2-3 drinks per day)
e. Heavily _____ (average 4 or more drinks per day)

Scale: 1 Drink = 12 oz. of Beer
5 oz. of Wine
1 oz. of Hard Liquor

❒ Yes ❒ No Have you ever been addicted to alcohol, prescription drugs, or street drugs?

Patient request for Patient Records

Date: _____

To: _____

Patient Name: _____

I hereby authorize the release of my Medical Records and request that they be transferred to:

Bear Chiro-Rehab Center
1106 Pulaski Highway
Bear, DE 19701

Patient Signature:_____

Social Security :_____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released
to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell
Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date:____/____/_____

Witness:_____ Date: ___/____/_____

PREGNANCY WAIVER

I hereby acknowledge that Physicians Plus has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____
Printed Name of Patient

_____
Signature of Patient/Authorized Representative of Patient

_____
Witness

Date: _____