PERSONAL INJURY
PATIENT HISTORY FORM – PI/PHF

Please Write Legibly

Name: ____ Today's Date: ________________

HISTORY OF OCCURRENCE

Date of accident: ________________ Time: ____________ ☐ AM ☐ PM
Driver of car: _________________________________ Where were you seated: ____________________________
Who owns the car? ____
Year and model of car: _____________________Year and model of opposing vehicle: ______________________
What was the approx. damage done to car you were in? __________________________
Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good
Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dry
Your car: ☐ Hit another car ☐Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side
Type of accident: ☐ Head-on collision ☐ Broad side collision ☐ Rear-end collision
☐ Front impact, rear-ended car in front
☐ Non-collision (tree, animal, etc): ____

IMPACT/SEAT BELT/HEADREST/SPEED

Describe in your own words what happened to you upon impact: _______________________________________
____
Did you see accident coming? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No
Were seat belts worn? ☐ Yes ☐ No
Were shoulder harnesses worn? ☐ Yes ☐ No
Does your car have headrests? ☐ Yes ☐ No
If yes, what was the position of those headrests compared to your head before the accident?
Top of headrest even with: ☐ bottom of head ☐ top of head ☐ middle of neck
Was your car braking? ☐ Yes ☐ No
Was your car moving at the time of the accident? ☐ Yes ☐ No
If yes, how fast would you estimate you were going? __________ MPH
How fast would you estimate the other vehicle was going? __________ MPH

HEAD/BODY POSITION/ABLE TO MOVE BODY

Head/Body position at time of impact: ☐ Head turned: ☐ Right ☐ Left ☐ Head looking back
☐ Head straight forward ☐ Body straight in sitting position ☐ Body rotated: ☐ Right ☐ Left
At the time of accident, recall what parts of your head or body hit what parts of the inside of your car:
____
As a result of the accident, you were: ☐ Rendered unconscious ☐ Dazed, circumstances vague
☐ Shaken up but could function
Could you move all parts of your body? ☐ Yes ☐ No
If no, what parts and why? ____
Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
If no, why not? ____

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? ☐ Yes ☐ No

If yes, what bleeding cuts did you sustain? ______________________________

If yes, what bruises did you sustain? ______________________________

Please describe how you felt. *PLEASE BE SPECIFIC*

Immediately after the accident: ______________________________

Later that ☐ Day ☐ Night: ______________________________

The next day(s): ______________________________

Check symptoms apparent since the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numbness in toes	☐ Chest pain
☐ Midback pain	☐ Tension	☐ Numbness in fingers	☐ Ringing/buzzing in ears	☐ Nervousness
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Eyes sensitive to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxious
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	☐ Other ____________

WORK STATUS HISTORY

Occupation: ______________________ Employer: ______________________

Have you missed time from work? ☐ Yes ☐ No

If yes: Full time off work __________ to __________ __________ to __________

Part time off work __________ to __________ __________ to __________

☐ Been unable to work since accident

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR 1/HOSPITAL/CLINIC SEEN: ______________________ Date of first visit: __________

Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you? ______________________________

What benefits did you receive from the treatment? ______________________________

Date of last treatment: __________

SECOND DOCTOR/HOSPITAL/CLINIC SEEN

DOCTOR 2/HOSPITAL/CLINIC SEEN: ______________________ Date of first visit: __________

Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you? ______________________________

What benefits did you receive from the treatment? ______________________________

Date of last treatment: __________

THIRD DOCTOR/HOSPITAL/CLINIC SEEN

DOCTOR 3/HOSPITAL/CLINIC SEEN: ______________________ Date of first visit: __________

Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you? ______________________________

What benefits did you receive from the treatment? ______________________________

Date of last treatment: __________

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints just before the accident? ☐ Yes ☐ No

If yes, please describe in detail: ____

PRIOR to this accident, have you **EVER** had symptoms similar to what you're experiencing now? ☐ Yes ☐ No

If yes, please explain (*briefly include past falls, injuries, accidents, operations, etc):* ____________________________

____

ACTIVITIES OF DAILY LIVING

Do you notice any activities of your **home** daily routines that are different **now** than from **before** the accident?

☐ Yes ☐ No If yes, list them as (be specific):

Those activities that you are unable to do are: ______________________________________

Those activities that are painful to do are: ____

Those activities that are difficult to do are: ____

PAIN LEVEL/SCALE OF RECOVERY

On a scale of 0-10, with 0 being no pain, and 10 being the highest, where would you rate yourself? (circle)

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

Please explain why: ____

Relative to where you were before this injury, how would you rate how much you have recovered so far? ____%

INDICATE ON ONE OF THESE DIAGRAMS HOW THE ACCIDENT HAPPENED

ATTORNEY ON CASE

Do you have an attorney on this case? ☐ Yes ☐ No

If yes, who? Name: ____

Address: ______________________________ City: ____________ State: ____ Zip: ________

Patient Signature:____ **Date:** ____________________

AUTOMOBILE ACCIDENT – INSURANCE DATE

Patient's Insurance Company Information

Company Name: ___________________________ PH #:__________ Policy #:_________________

PO Box/Street #______________________________________ Adjuster's Name:_________________

City/State/Zip: ______________________________________

Insured's Insurance Information

Insured's name if other than patient: _________________________________ PH #:_________________

Company Name: ___________________________ PH #:__________ Policy #:_________________

PO Box/Street #______________________________________ Adjuster's Name:_________________

City/State/Zip: ______________________________________

Other Driver's Insurance Information

Other driver's name (if another car was involved): ______________________ PH #:_________________

Company Name: ___________________________ PH #:__________ Policy #:_________________

PO Box/Street #______________________________________ Adjuster's Name:_________________

City/State/Zip: ______________________________________

DOCTOR'S LIEN
NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira **Dr. Jody Ferreira**
6 Seeley Lane
Eliot, ME 03903
Phone: 207-439-9242
Fax: 207-438-0246

I, THE UNDERSIGNED, HERBY AUTHORIZE ____
(NAME OF PAYING PARTY)
TO PAY MY CLAIMS DIRECTLY TO **NATURAL CARE WELLNESS CENTER (DR. SCOTT FERREIRA)** FOR SERVICES RENDERED FOR CHIROPRACTIC, MASSGE, AND/OR OTHER THERAPIES PROVIDED TO ME AT THIS OFFICE DUE TO A PERSONAL INJURY OR WORKMAN'S COMPENSATION CASE.

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY PAYMENTS NOT COVERED OR AUTHORIZED BY THE INSURANCE COMPANY HANDLING MY CASE. FURTHERMORE, IN THE EVENT THAT THE INSURANCE COMPANY SENDS THE PAYMENTS TO ME INSTEAD OF **NATURAL CARE WELLNSS CENTER** FOR THE ABOVE SERVICES RENDERED, I WILL MAKE A PROMPT PAYMENT WITHIN 30 DAYS OF RECEIVING THE INSURANCE REIMBURSEMENT TO **NATURAL CARE WELLNESS CENTER (send to the address above)**.

CLAIM#: ________________________________

POLICY #: ________________________________

DATE OF ACCIDENT: ________________________

PATIENT NAME (print): ____

SIGNATURE: ____

TODAY'S DATE: ___________________________

BACK INDEX

Patient Name: ____ Date: ______________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please fill in the one statement that most closely describes your problem.

Pain Intensity
⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping
⓪ I get no pain in bed .
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain, my normal sleep is reduced by less than 25%.
③ Because of pain, my normal sleep is reduced by less than 50%.
④ Because of pain, my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting
⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than ½ hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing
⓪ I can stand as long as I want without pain.
① I have some pain with standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than ½ hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking
⓪ I have no pain while walking.
① I have some pain while walking but it does not increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than ½ mile without increasing pain.
④ I cannot walk more than ¼ mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care
⓪ I do not have to change my way of washing/dressing to avoid pain.
① I do not normally change my way of washing/dressing even though it causes some pain.
② Washing/dressing increase the pain but I manage not to change my way of doing it.
③ Washing/dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing/dressing without help.
⑤ Because of the pain I am unable to do any washing/dressing without help.

Lifting
⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling
⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling, which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life
⓪ My social life is normal and I get no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain
⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected/# of sections with a statement selected x 5)] x 100

Back Index Score

☐

NECK INDEX

Patient Name: ______________________________________ Date: ________________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please fill in the one statement that most closely describes your problem.

Pain Intensity
⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worse imaginable at the moment.

Sleeping
⓪ I have no trouble sleeping .
① My sleep is slightly disturbed (less than 1 hour sleepless)
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless)
⑤ My sleep is completely disturbed (5-7 hours sleepless)

Reading
⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration
⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work
⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care
⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dresses, I wash with difficulty and stay in bed.

Lifting
⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving
⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want without slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation
⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of pain
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches
⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected/# of sections with a statement selected x 5)] x 100

Neck Index Score