Patient # ____________

ACCIDENTAL INJURY HISTORY

Date ____________

Name ______________________________ Address ______________________________

City ____________________ State ____________________ Zip ____________

Phone ____________ Date of Birth ____________ Age ________ Occupation ____________

Employed by ______________________________

Date of Accident ____________ Hour ____________ AM ________ PM Location ____________

How Did Accident Occur? ______ Auto Collision ______ On-the-Job Injury ______ Fall ______ Other ______

Please Describe The Accident Circumstances Completely ______________________________

____

____

List The Extent of The Injuries As You Know Them ______________________________

____

____

UNDERLINE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

HEAD INJURIES

784.0 Headaches
Tension, Migraine, Vasomotor, Sick
307.81 346.9 346.9 346.1
780.9 Loss of Memory
780.4 Lightheadedness
780.2 Fainting
379.91 Eye Pain
780.4 Loss of Balance
780.4 Dizziness
389.9 Loss of Hearing
388.7 Pain in the Ears
388.3 Ear Noises
850.9 Concussion
692.79 Lights Bother Eyes
781.1 Loss of Smell or Taste

NECK INJURIES

723.5 Stiffness of the Neck
723.1 Soreness of the Neck
723.5 Difficult Neck Movement
728.85 Muscle Spasms in Neck
719.6 Grinding Sounds in the Neck

SHOULDERS, ARMS, AND CHEST INJURIES

719.41 Shoulder Pain
724.1 Pain Between The Shoulders
728.9 Can't Raise The Arm or Hand
728.85 Muscle Spasms in the Shoulders
729.5 Numbness or Pain in the Arms, Hands, or Fingers
991.9 Cold Hands
729.5 Shoulder, Elbow, or Wrist Pain
728.9 Loss of Strength in Arms or Hands
786.5 Chest Pain
786.09 Shortness of Breath
786.5 Rib Pain
354.0 Carpal Tunnel Syndrome

ABDOMINAL SYMPTOMS:

306.4 Nervous Stomach
Nausea, Gas, Constipation, Diarrhea
787.0 787.3 564.0 558.9

LOWER BACK SYMPTOMS:

724.79 Painful Tailbone
722.10 Low Back Pain
Back is Aggravated by Working, Lifting, Stooping, Standing, Sitting, Bending, Coughing, or Lying Down
724.5 Difficulty in Standing Erect

LEG INJURIES:

729.5 Numbness or Pain Extending in Either Leg
728.85 Muscle Spasms
719.46 Pain in Buttocks, Knee Joint, Calves, or Ankles
729.5 719.47
991.9 Feet Are Cold
719.07 Swollen Ankles
719.45 Pain in the Hip, Knee, Ankles, or Feet
719.46 719.47 719.47

GENERAL SYMPTOMS:

311.0 Depression
780.7 Fatigue
780.52 Insomnia
783.2 Loss of Weight
788.4 Frequent Urination
799.2 Nervousness
799.2 Jittery
287.2 Bruises
998.2 Lacerations
829.0 Broken Bones
780.0 Knocked Unconscious or Stunned

(over)

Have you consulted with other doctors for your injuries?______Yes______ No

Did You Report The Injury To Your Foreman, Employer, Or Police?______Yes______No

Did He (They) Recommend Care At Our Office?______Yes______No

If Auto Accident, Were You____Driver ______Passenger______ Pedestrian

If Auto Collision Were You Struck From____Behind______Right Side______Left Side______Front
____Auto Was Parked

Did Your Car Strike The Other(s) Involved______Yes______No: Or Did The Other Car Strike Yours?
____Yes______ No______Undetermined

As A Result of The Accident Was A Traffic Citation Issued to You______Yes______No;
To The Driver of The Other Car______Yes______No;
To The Dirver Of Your Car______Yes______No

Amount of Damage To The Car______________________________

Did You Require Hospitalization After The Accident?______Yes______No
Which Hospital______________________How Many Days______________

Have You Lost Any Days of Work?______________________Dates: ______________

Total Disability______________________Total House Confinement ______________

Partial Disability______________________Date You Returned to Unrestricted Work ______________

INSURANCE COMPANIES INVOLVED:

My Company______________________Policy Number______________

Company of Person Responsible for Injuries______________________________

Have You Contacted The Insurance Adjustor or Company Representative Regarding This Claim?
_______Yes______No

Have You Consulted An Attorney For This Injury?______Yes______No
His Name______________ Address______________Telephone No. ______________

I hereby state that the information on both sides of this form is true and correct. I authorize the Bozeman Back & Neck Clinic to examine, make x-rays, treat me and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination and treatment records, and the prognosis to my employer, attorney, or insurance company.

Patient's Signature:______________________ SS# ______________________ Date: __________

Guardian or Spouse's
Signature Authorizing Care:______________________________ Date:__________