Benessere Chiropractic, Massage and Fitness, LLC

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Auto/Personal Injury

Patient Registration

Today's Date_____

Name_____ Date of Birth _____
Address_____ Home Phone_____
City _____State ____Zip_____ Cell Phone_____
Social Security #_____ Work Phone_____
M__ F__ Preferred Gender Designation: _____
Employer _____Occupation _____email_____
Marital Status: S M W D P Spouse's Name_____ # of children_____
How did you hear about us? _____
Emergency contact: _____ Phone: _____
Date of the injury? _____

Personal Insurance Company: _____
Name of Insured:_____ ID No: _____
Group No:_____ Claim No:_____ Medicare No: _____
Secondary Insurance Company:_____
Name of Insured:_____ ID No: _____
Group No: _____ Claim No: _____ Medicare No: _____

Agreement

I understand that my Automotive Insurance policy is a contract between my insurance carrier and myself. Benessere Chiropractic, Massage and Fitness, LLC (Benessere) will bill my Insurance Company as a courtesy and does not guarantee payment by my Insurance Company. I agree that I am personally responsible for all the services rendered to me by the practitioners at Benessere. I authorize the release of any prior medical information necessary to be properly evaluated by Chiropractors at Benessere and to assist in the processing of my automotive insurance claim. I authorize my Insurance Company to send payments for services rendered directly to Benessere.

Patient Signature: _____ Date: _____

Person Authorizing Care (if different from patient) Please print and sign:
_____Date: _____
Relationship to insured_____

Automotive Insurance Data

Auto insurance information for the vehicle you were in:

Company Name: _____ Phone # _____
Address: _____ Policy # _____
_____ Claim # _____
Adjuster's Name: _____

Your own auto insurance information (if different):

Company Name: _____ Phone # _____
Address: _____ Policy # _____
_____ Claim # _____
Adjuster's Name: _____

Other driver's auto insurance information:

Company Name: _____ Phone # _____
Address: _____ Policy # _____
_____ Claim # _____
Adjuster's Name: _____

Details of the Collision:

Date of collision: _____ Time: _____ [ ] AM [ ] PM
Driver of the car: _____ Where were you seated? _____
Owner of the car: _____ Year and model of car:_____
What was the approximate cost of damage done to the car you were in?
$ _____

Visibility at the time of the accident: [ ] Poor [ ] Fair [ ] Good
Road conditions at the time of accident: [ ] Icy [ ] Rainy [ ] Wet
[ ] Clear [ ] Dark

Your car: [ ] Hit another car OR [ ] was hit in the: [ ] Right [ ] Left
[ ] Rear [ ] Front [ ] Side
Other_____

Type of accident: [ ]Head-on collision [ ]Broadside collision [ ]Rear-end collision
[ ] Front impact (your car hit a car in front of yours)
[ ] Rear impact followed by front impact
[ ] Non-collision:_____

In your own words, describe what happened to you upon impact:

_____

_____

_____

_____

Did you see the accident coming? [ ] No [ ] Yes

Was the car you were in: [ ] Braking [ ] Stopped with foot on brake [ ] Parked
Were you pre-warned the accident was about to happen? [ ] No [ ] Yes
Did you brace for the impact? [ ] No [ ] Yes
Were you wearing a seat belt? [ ] No [ ] Yes
Were you wearing a shoulder harness? [ ] No [ ] Yes
Did the airbag(s) deploy? [ ] No [ ] Yes: [ ] Front [ ] Side

Did your head hit anything inside the automobile? [ ] No [ ]Yes
[ ] Windshield [ ]Side window [ ] Side pillar next to window [ ] Other_____

Did the car you were in have headrests? [ ] No [ ] Yes
If yes, what was the position of the headrest in relation to your head before impact?

[ ] Top of headrest even or below bottom of head
[ ] Top of headrest even or above top of head
[ ] Top of headrest even with middle of neck

Head/body position at time of impact: [ ]Head turned: [ ]Right [ ] Left
[ ] Looking back to the right
[ ] Looking back to the left
[ ] Head straight forward
[ ] Body straight forward
[ ] Body rotated: [ ] Right [ ] Left

Immediately after impact were you: [ ] Unconscious [ ] Dazed [ ] Shaken up

Could you move all parts of your body? [ ] No [ ] Yes
If no, which parts could not and why? _____

_____

Were you able to get out of the car and walk unaided? [ ] No [ ] Yes
If no, why not (describe in detail)?

_____

_____

First Doctor / Hospital / Clinic Visited Since the Crash

Did you seek medical help after the crash? [ ] No [ ] Yes, Where?

_____

If yes, how did you get there? [ ] Someone drove me [ ] Drove myself
[ ] Ambulance

Whom did you see? _____ Date of first visit: _____

Was imaging done? [ ] No [ ] Yes, What type of imaging was done and what body area was evaluated?

_____

Were you treated? [ ] Yes [ ] No
If yes, what treatment was provided? _____

What benefits did you receive from treatment? _____

Date of last treatment: _____

Second Doctor / Hospital / Clinic Visited

Name of facility _____

Whom did you see? _____ Date of first visit: _____

Was imaging done? [ ] No [ ] Yes, What type and location of imaging

_____

Were you treated? [ ] Yes [ ] No
If yes, what treatment was given? _____

What benefits did you receive from treatment? _____

Date of last treatment: _____

Work History

Occupation: _____ Have you missed time from work? [ ] No [ ] Yes
If yes, [ ] Full-time off work: From _____ to_____
[ ] Part-time off work: From _____ to_____
[ ] Unable to work since the crash
[ ] Light duty work. Limitations: _____

Prior Similar Symptoms

Did you have any physical complaints before the collision? [ ] No [ ] Yes
Explain_____
_____
Prior to this accident, have you EVER had symptoms similar to what you're experiencing now? [ ] No [ ] Yes Please explain
_____
_____
_____

Activities of daily living

Do you have any common daily activities that are limited or that you cannot do now since the crash? [ ] No [ ]Yes

Activities that you are unable to do: _____
_____

Activities that are painful to do: _____

Activities that are difficult to perform due to pain: _____
_____

Injuries Immediately After the Collision

Did you have cuts and/or bruises? [ ] No [ ] Yes
If yes, describe location(s) and size(s) of the cuts and/or bruises:
_____
_____

Detailed description of how you felt overall:
Immediately after the crash: _____
Later that [ ] day [ ] night:_____
The next day(s): _____
Can you cook and clean for yourself? _____
Has your sleep been affected? [ ] No [ ]Yes [ ] Due to pain
How many total sleeping hours per night? _____
How many hours at a time do you sleep? _____
Do you feel rested from sleeping? [ ] No [ ] Yes

First Priority for Treatment

Body region: _____

When did symptoms start after the crash? _____

What makes the symptom(s) better? _____

What make the symptom(s) worse? _____

Symptoms worse in the: [ ] Morning [ ] Evening [ ] Unaffected by time of day
[ ] Worse in the morning then better mid day then gets worse in evening
[ ] Constant through the day [ ] Worse on days that you go to work?

Describe quality/type of symptoms:
Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing
Other: _____

Do symptoms radiate to arms, legs or into your head? (Describe in detail)
_____

Describe the quality / type of radiation:
Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 _____ 10 (Worst pain/ brings you to tears)

Treatment for this symptom since the crash? [ ] No [ ] Yes where? _____

Treatment for symptoms in this area any time in your life before the crash?

Where? _____

When? _____

Response to prior treatment? _____

Type of prior treatment? _____

Additional information: _____
_____

Second Priority for Treatment

Body region: _____

When did symptoms start after the crash? _____

What makes the symptom(s) better? _____

What make the symptom(s) worse? _____

Symptoms worse in the: [ ] Morning [ ] Evening [ ] Unaffected by time of day
[ ] Worse in the morning then better mid day then gets worse in evening
[ ] Constant through the day [ ] Worse on days that you go to work?

Describe quality/type of symptoms:
Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing
Other: _____

Do symptoms radiate to arms, legs or into your head? (Describe in detail)
_____

Describe the quality / type of radiation:
Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 _____ 10 (Worst pain/ brings you to tears)

Treatment for this symptom since the crash? [ ] No [ ] Yes where? _____

Treatment for symptoms in this area any time in your life before the crash?

Where? _____

When? _____

Response to prior treatment? _____

Type of prior treatment? _____

Additional information: _____
_____

Third Priority for Treatment

Body region: _____

When did symptoms start after the crash? _____

What makes the symptom(s) better? _____

What make the symptom(s) worse? _____

Symptoms worse in the: [ ] Morning [ ] Evening [ ] Unaffected by time of day
[ ] Worse in the morning then better mid day then gets worse in evening
[ ] Constant through the day [ ] Worse on days that you go to work?

Describe quality/type of symptoms:
Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing
Other: _____

Do symptoms radiate to arms, legs or into your head? (Describe in detail)
_____

Describe the quality / type of radiation:
Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 _____ 10 (Worst pain/ brings you to tears)

Treatment for this symptom since the crash? [ ] No [ ] Yes where? _____

Treatment for symptoms in this area any time in your life before the crash?

Where? _____

When? _____

Response to prior treatment? _____

Type of prior treatment? _____

Additional information: _____
_____

Past Health History

Have you ever been under Chiropractic care? [ ] No [ ] Yes (DC /Clinic names):

_____

Reason for treatment: _____

Response to treatment: _____

Techniques used: _____

Do you take vitamins or minerals? [ ] No [ ] Yes

Please list:_____

Please list all medications: _____

Have you had any X-Ray, MRI, CT scans in the past 10 years? [ ] No [ ] Yes

Date	Test	Body Region	Doctor/Testing Center
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever broken/fractured a bone?

Date:	Bone/Region:	Treatment	Completely Healed?
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes

Have you ever been involved in a prior car crash?

Date:	Description:	Injuries:	Resolved:
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes

Please list all surgeries or major illnesses.

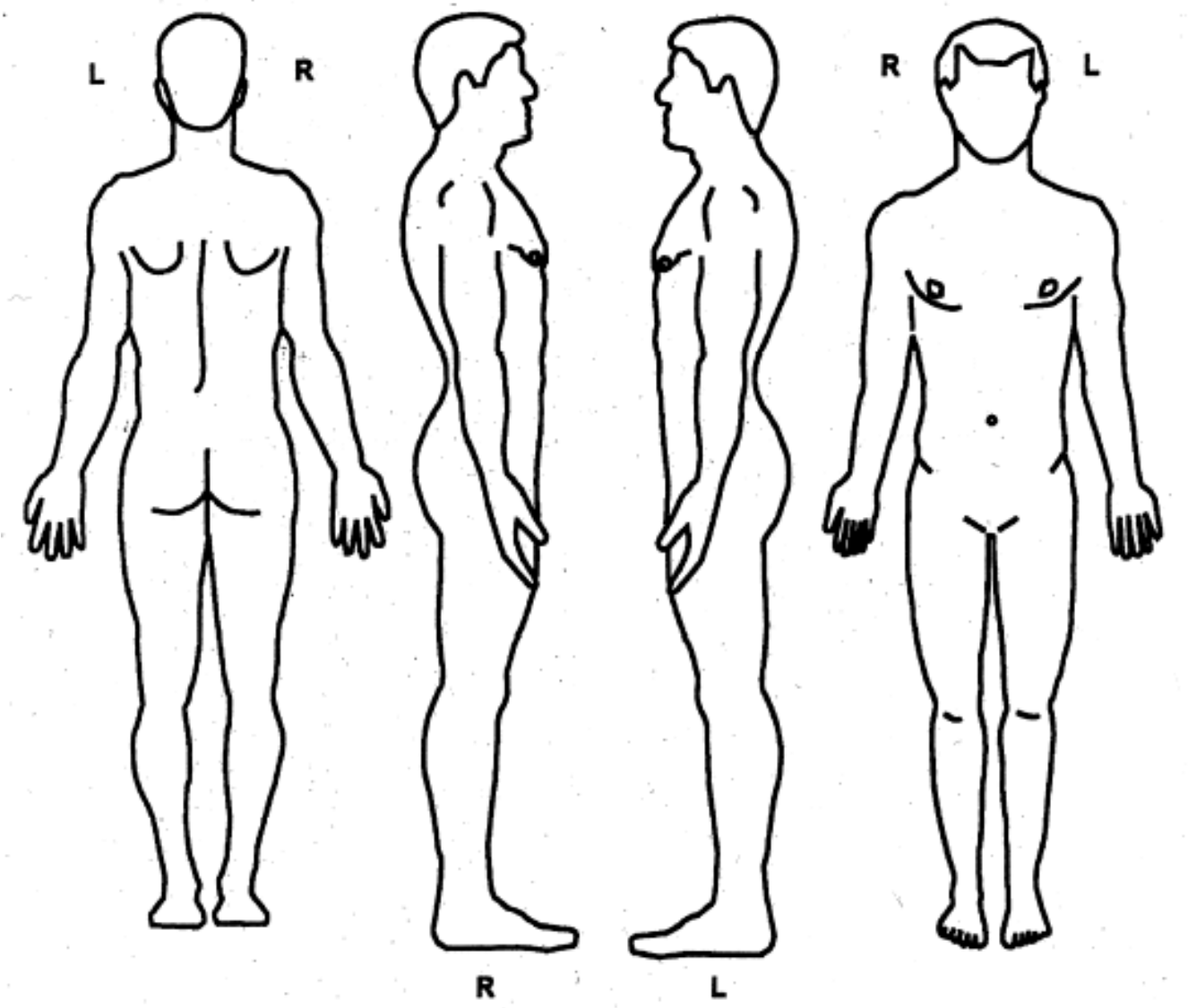
Date:	Description:	Resolved:
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes

Other injuries (falls, concussions, trauma):

Date:	Description:	Resolved:
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes

	Heavy	Moderate	Light	None	Do you wear?
Alcohol	[ ]	[ ]	[ ]	[ ]	[ ] Orthotics
Tobacco	[ ]	[ ]	[ ]	[ ]	[ ] Heel lifts
Coffee	[ ]	[ ]	[ ]	[ ]	[ ] Insoles
Exercise	[ ]	[ ]	[ ]	[ ]	[ ] Braces
Sleep	[ ]	[ ]	[ ]	[ ]	

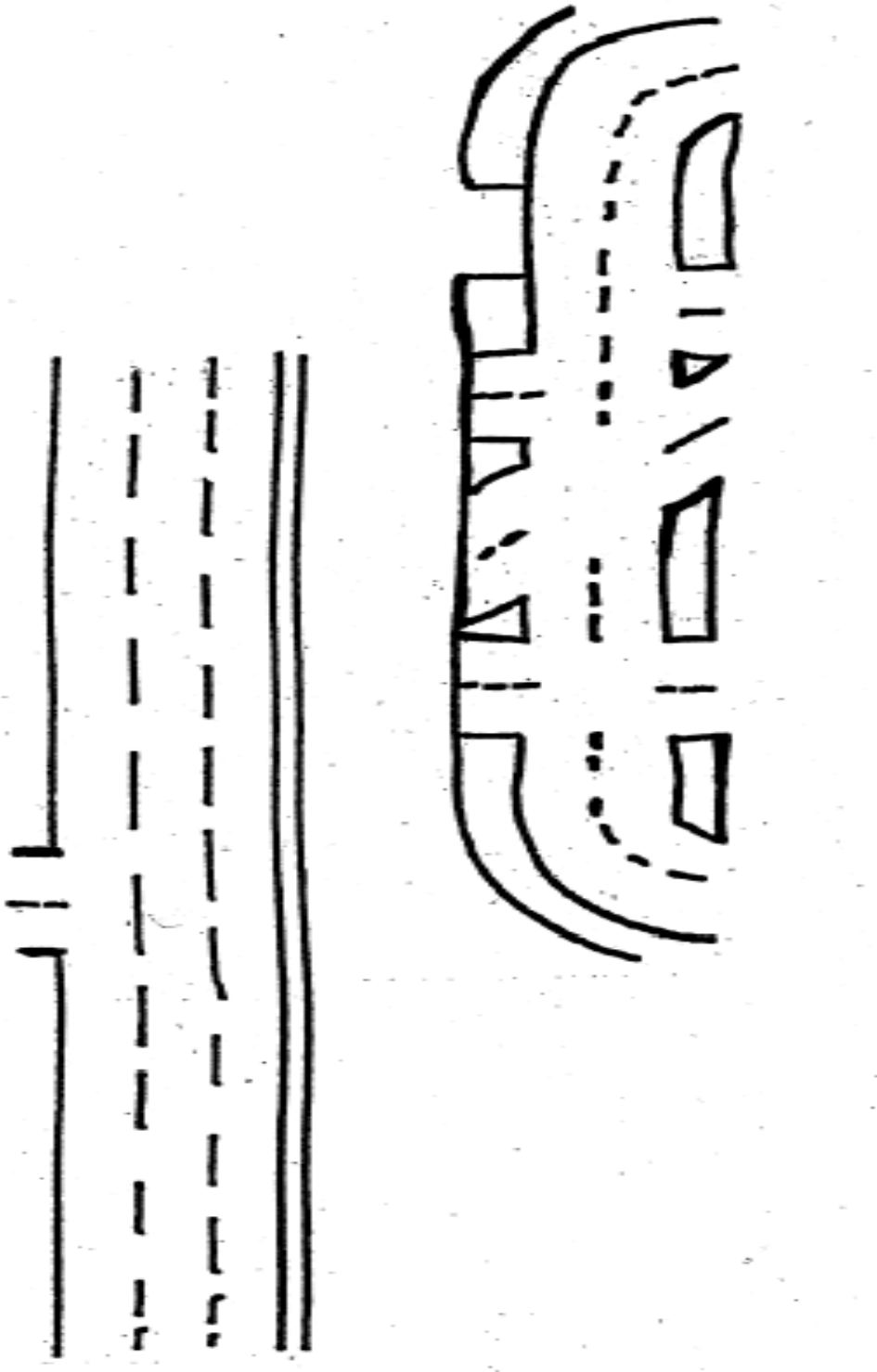
Pain Drawing



Mark as follows:
A = Ache B = Burning N = Numbness P = Pins & Needles / Tingle S = Stabbing
O = Other, describe _____
_____
_____

Crash Diagram

Please indicate on the diagram the positions of the vehicle(s) involved in the collision.



Payment Policy

We require payment at the time of service. If you have private health insurance we ask that you pay your co-pay or co-insurance at the time of service. If you have a yearly deductible, you must meet that as your policy specifies. We may or may not bill, or you may bill, your insurance company. If payment for any part of your treatment is denied by your insurance carrier you will assume full responsibility for payment and will pay independent of any appeal process with the insurance carrier.

In the case of personal injury, auto accident, or workers' compensation claims, we will bill the entire amount of each visit to your insurance company. The costs of supplies, supports and/or supplements not paid for by your insurance company are your responsibility.

If you have any questions concerning our payment policy, please feel free to ask the receptionist.

Cancellation Policy

We require 24 hours notice for all cancellations. If you cancel with less than 24 hours notice, you will be charged 50% of the total charges for the scheduled visit. If you fail to attend your appointment and do not call to cancel, you will be charge IN FULL for the total visit. We send reminder texts as a courtesy. It is your responsibility to be on time for your appointments.

I have read and understood the above payment and cancellation policies and agree to follow them while utilizing the services at Benessere Chiropractic Massage and Fitness, LLC.

Signed_____ Date_____