Complete Wellness & Integrated Health Center *Stephanie Cluver, D.C*
DBA: Clinton Chiropractic Center
211 S. Quincy St. Clinton, IL 61727 Phone (217) 935-6555

Personal Injury History

ABOUT YOU

PATIENT NAME:			DATE OF BIRTH
ADDRESS:	P.O. BOX OR APARTMENT #	CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:	CELL PHONE NUMBER:	GENDER [ ] MALE [ ] FEMALE	MARITIAL STATUS: [ ] SINGLE [ ] MARRIED [ ] OTHER
SOCIAL SECURITY NUMBER:	RACE: [ ] WHITE [ ] BLACK OR AFRICAN AMERICAN [ ] HISPANIC OR LATINO [ ] OTHER		LANGUAGE: [ ] ENGLISH [ ] SPANISH [ ] OTHER
EMPLOYER NAME:	EMPLOYER PHONE NUMBER:	EMPLOYER ADDRESS:	
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE NUMBER:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	HOW DID INJURY OCCUR? [ ] AUTO COLLISON [ ] ON THE JOB [ ] OTHER	
IF WORK INJURY, DID YOU REPORT ACCIDENT TO YOUR EMPLOYER: [ ] YES ____NO		IF AUTO ACCIDENT, HOW MANY PEOPLE WERE IN THE CAR?	
DID YOU HIT YOUR HEAD? [ ] YES [ ] NO		WERE YOU KNOCKED UNCONSCIOUS? [ ] YES [ ] NO	
WERE YOU TAKEN BY AMBULANCE? [ ] YES [ ] NO	WHERE WERE, YOU TAKEN?		WERE YOU WEARING A SEAT BELT? [ ] YES [ ] NO
IF AUTO ACCIDENT, WERE YOU STRUCK FROM? [ ] BEHIND [ ] FRONT [ ] LEFT SIDE [ ] RIGHT SIDE		WERE THE POLICE ON THE SCENE? [ ] YES [ ] NO	WAS A REPORT FILED? [ ] YES [ ] NO
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? ____YES ____NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ____IMPROVING ____GETTING WORSE ____GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? [ ] YES [ ] NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? [ ] YES [ ] NO		IF YES PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATED TO THIS CASE? [ ] YES [ ] NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? [ ] YES [ ] NO		IF YES, PLEASE DESCRIBE:	

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	ADDRESS OF INSURANCE COMPANY:
ADJUSTERS NAME:	ADJUSTERS PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

ACCIDENT INFORMATION

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: _____

_____

_____

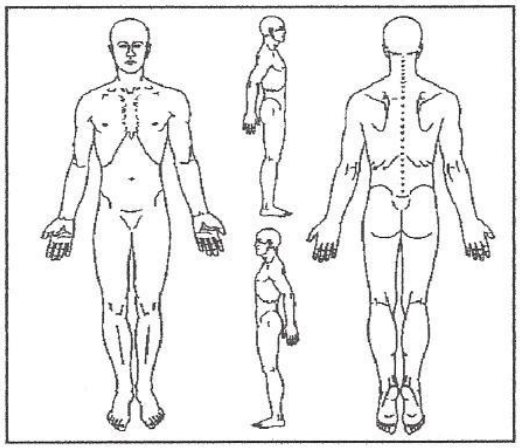
_____

INSTRUCTIONS: CHECK ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT:

☐ HEADACHE	☐ DIZZINESS	☐ LIGHT BOTHERS EYES
☐ NECK PAIN	☐ HEAD SEEMS HEAVY	☐ LOSS OF MEMORY
☐ NECK STIFFNESS	☐ PINS & NEEDLES IN ARMS	☐ EARS RING
☐ SLEEPING PROBLEMS	☐ PINS & NEEDLES IN LEGS	☐ FACE FLUSHED
☐ BACK PAIN	☐ NUMBNESS IN FINGERS	☐ BUZZING IN EARS
☐ NERVOUSNESS	☐ NUMBNESS IN TOES	☐ LOSS OF BALANCE
☐ TENSION	☐ SHORTNESS OF BREATH	☐ FAINTING
☐ IRRITABILITY	☐ FATIGUE	☐ LOSS OF SMELL
☐ CHEST PAIN	☐ DEPRESSION	☐ LOSS OF TASTE
☐ DIARRHEA	☐ FEET FEEL COLD	☐ UPSET STOMACH
☐ CONSTIPATION	☐ HANDS FEEL COLD	☐ OTHER: _____
☐ FEVER	☐ COLD SWEATS	☐ OTHER: _____

INSTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N = Numbness P = Pain T = Tingling S = Stiffness/Soreness



COMMENTS:

_____

_____

_____

_____

_____

_____

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW: _____

_____

_____

WOMEN ONLY
Are you pregnant?
☐ Yes ☐ No

DOCTOR ONLY

DOCTOR COMMENTS: _____

_____

_____

SIGNATURE

PATIENT (OR GAURDIAN IF PATIENT IS A MINOR) SIGNATURE: DATE:

AUTHORIZATIONS AND FINANCIAL

Permission to Discuss: I give my permission for Dr. Stephanie Cluver and the staff of the Clinton Chiropractic Center to discuss my condition and financial concerns with:

1_____ Relationship _____

2_____ Relationship _____

3 _____Relationship _____

Patient's (or person responsible if a minor) Signature: _____

Financial Policy: I hereby authorize the assignment of my benefits to be paid directly to the Clinton Chiropractic Center. I realize I am financially responsible for all non-covered services, and that the fees of these services are subject to change at any time. I authorize the doctor to release any information requested for payment. Furthermore, I understand that the doctor shall have the right as her option to collect a delinquent charge, interest, and/or accelerate the maturity of the total of payments. It is my responsibility to pay all attorney fees, court, and/or collection cost and disbursements made to collect this account. Any amount remaining unpaid after the expiration of the maturity date shall draw interest at the highest allowable rate in the state of Illinois. Patient authorizes the Clinton Chiropractic Center to deposit checks received on patient's account when made out to the patient.

Medicare Patients Only: I understand that Clinton Chiropractic Center does not accept assignment of Medicare, but we will bill all services and any money paid will be sent directly to me. Therefore, I realize I am financially responsible for all services, and that the fees of these services are subject to change at any time.

Please initial: _____

Patient authorizes EFT (Electronic Funds Transfer) of delinquent accounts up to account balance, in the event of default. Please choose just one of the options below:

Debit or Credit Card, please provide the following:

☐ MasterCard ☐ Visa ☐ Discover

Name on Card: _____

Card number: _____

Security Code: _____

Expiration Date: _____

Bank Account, please provide the following:

☐ Checking ☐ Savings

Name on Account: _____

Name of Bank: _____

Routing number: _____

Account number: _____

Signature: _____Date: _____