EASTMAN-KINGREY CLINIC
WESTLAKE, LA

MVA CONFIDENTIAL HEALTH HISTOR'
Date:_____ File:_____

PERSONAL

Name: _____ Sex: M/F Age:_____Date of Birth:_____
Phone (home):_____(cell):_____ (work): _____
What do you prefer to be called?: _____ SS#: _____Height:_____ Weight: _____
Marital Status: Single__Married__ Divorced__ Widowed__ Number of children:_____
Address: _____ City:_____ State:_____ Zip: _____
Employer: _____ How long?: _____ Employer Address:_____
Occupation: _____ How long?: _____
Spouse: _____ Spouse's employer: _____
Referred by: _____ In case of emergency notify: _____
Preferred Language: _____

INSURANCE

Your Insurance Co. _____ Other Insurance _____
Your Attorney _____ Adjustor _____
Have you notified your insurance company yet? Yes _No____ Claim # _____

ACCIDENT

Accident date _____Time _____am/pm City/Street_____
You were? __ Driver __Passenger (__mid front __right front __left rear __mid rear __right rear)
Your Vehicle _____
PLEASE ANSWER:

Y/N Belted? If yes, __shoulder and lap __shoulder __lap
Y/N Aware that the accident was going to happen? If yes, did you brace? __ yes __no
Y/N Was your head facing to the side? If yes, which side? __left __right __back __rear view mirror
Y/N Did you lose consciousness? If yes, how long? _____
Y/N Was there an airbag inflation?
Y/N Police report made? Which Department? _____
Y/NDid you go to the hospital the day of the accidents? If yes, how? __ Ambulance __Drove Self __Driven by someone else
Y/N Have you been to the hospital or any other
doctor since the day of the accident?

CURRENT CONDITION

Please describe the principal health problems for which you came to this office: _____
_____
How and when did symptoms first occur?: _____
List any other doctors seen for these problems: _____
List any diagnosis(es) and type of treatment: _____

Are you taking any medications for the current condition?: Yes__ No__ Have they helped?: A lot__ Some__ Not at all __
Type of medications?: Pain killers__ Muscle relaxers__ Anti-inflammatory__ Other_____
Have you lost any days of work?: Yes__ No__ Dates:_____
Have you had similar symptoms before?: Yes__ No__ When?:_____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make to me or you based in whole or in part upon the charges made for your services.
2. In the event any insurance company obligated to contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit, I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.

Date_____ Signature _____

HEALTH HISTORY

Check the following conditions/procedures you have/had:

__Anemia
__Cancer
__ Diabetes
__ Epilepsy
__ Fibromyalgia
__Gout
__Hepatitis
__HIV/AIDS
__Lupus
__ Multiple Sclerosis
__Osteoporosis
__ Rheumatoid Arthritis
__ Thyroid Condition
__ Urinary Tract Infections
__Venereal Disease
__Asthma
__Emphysema
__Tuberculosis
__Artificial Joints
__ Bone Fracture
__ Bone Fusion
__ Disc Herniation
__Dislocations
__Hernia
__Sciatica
__Scoliosis
__Tendon/Ligament Rupture
__ TMI Condition
__ Whiplash
__Arteriosclerosis
__ Cardiovascular Disease
__ Heart Attack/Stroke
__ Heart Defect
__Heart Murmur
__High Blood Pressure
__Low Blood Pressure
__Pacemaker
__Colitis
__ Gallbladder Condition
__ Gastric Reflux
__ Hemorrhoids
__Kidney Condition
__ Liver Condition
__Rectal Polyps
__ Ulcers
__Endometriosis
__ Hormone Replacement
__ Ovarian/Uterine Cyst
__Prostate Condition
__Testicle Condition

Please Circle the appropriate letter for any of the following symptoms:

O-OCCASIONAL
F- FREQUENT
C-CONSTANT

O F C- Severe/frequent Headaches
O F C- Jaw Pain
O F C- Eye Problems
O F C- Sinus Problems
O F C- Ear Problems
O F C- Nose Bleeding
O F C- Nose Discharge
O F C- Sore Throat
O F C- Dental Problems
O F C- Swollen Lymph Nodes

GENITOURINARY
O F C- Bladder Trouble
O F C- Excessive Urine
O F C- Painful Urination
O F C- Discolored Urine
O F C- Urinary Infection

RESPIRATORY
O F C- Difficulty Breathing
O F C- Coughing Blood
O F C- Coughing Phlegm
O F C- Chest Pain

CARDIOVASCULAR
O F C- Pain over Heart
O F C- Rapid Heartbeat

GASTROINTESTINAL
O F C- Weight Trouble
O F C- Excessive Thirst
O F C- Excessive Hunger
O F C- Poor Appetite
O F C- Heartburn
O F C- Abdominal Pain
O F C- Nausea/Vomiting
O F C- Diarrhea
O F C- Constipation
O F C- Black Stool
O F C- Bloody Stool

MUSCULOSKELETAL
O F C- Back Pain
O F C- Neck Pain
O F C- Pain Between Shoulders

PAIN OR NUMBNESS IN :
O F C- Shoulders
O F C- Arms
O F C- Elbows
O F C- Hands
O F C- Hips
O F C- Legs
O F C- Knees
O F C- Feet
O F C- Swollen/Stiff Joints
O F C- Loss of Strength
O F C- Walking Problems

NERVOUS
O F C- Seizures
O F C- Fainting
O F C- Dizziness
O F C- Paralysis
O F C- Loss of Feeling

FEMALES ONLY:
O F C- Vaginal Discharge
O F C- Irregular Vaginal Bleeding
O F C- Vaginal Pain
O F C- Breast Pain
O F C- Breast Lumps
O F C- Hot Flashes

Please Answer

List any health conditions within the last year:

_____
_____
_____

List any medications not listed previously that you currently take:

_____
_____
_____

List approximate date of any other operations, diseases, serious illnesses or accidents you have had:

_____
_____
_____
_____
_____
_____
_____
_____

DO YOU:

Wear heel lifts, arch supports, sole lifts, or inner soles? Y/N
Smoke? Y/N
Exercise? Y/N
Take Vitamins? Y/N

Allergies: _____
Usual sleeping position? Back__ Stomach__ Right Side__ Left Side __
Mattress: Age: ___ Type: _____ Is it comfortable: Yes__ No __
How would you rate your overall health?: Excellent_ Good_ Fair_ Poor_
Received chiropractic care before?: Yes __ No __

FEMALES ONLY

Are you currently pregnant?: Yes __ No __
If yes, due date?: _____
Are you currently menstruating?: Yes __ No __

Doctor's Notes:

PATIENT SIGNATURE: _____ **DATE:** _____

NAME: _____ DATE: _____ FILE #: _____

Functional Rating Index

Please circle the number which most closely descries your condition right now.

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need To Go Slowly	Moderate Pain; Need Some Assistance	Severe Pain; Need 100% Asssistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

0	1	2	3	4
Can Do Usual Work Plus Unlimited Extra Work	Can Do Usual Work; No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

0	1	2	3	4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

Please Turn Over