BODY THERAPEUTICS

ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

DATE OF ACCIDENT _____ HOUR OF ACCIDENT _____ AM PM

TYPE OF ACCIDENT: ☐ WORK RELATED ☐ TRAFFIC ☐ OTHER

WORK RELATED ACCIDENT

EMPLOYER _____ TYPE OF BUSINESS _____

WAS ANY EQUIPMENT, MACHINERY AND/OR OBJECT RELATED TO ACCIDENT? WHAT KIND? _____

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER? ☐ YES ☐ NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

TRAFFIC ACCIDENT

WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? ☐ TRUCK ☐ CAR ☐ MOTORCYCLE ☐ OTHER

WERE YOU A ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN?

IF A PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE CAR _____

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? ☐ YES ☐ NO MPH? _____

DID YOUR VEHICLE HIT OTHER VEHICLE/S? ☐ YES ☐ NO WHERE? _____

DID OTHER VEHICLE/S HIT YOUR VEHICLE? ☐ YES ☐ NO WHERE? _____

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? ☐ YES ☐ NO

WERE TRAFFIC CITATIONS ISSUED? ☐ YES ☐ NO TO WHOM? _____

DESCRIBE ACCIDENT INCLUDING CAUSE/S AND SURROUNDING CIRCUMSTANCES _____

_____

_____

PRESENT COMPLAINT

- ☐ HEADACHE
- ☐ HEAD SEEMS TOO HEAVY
- ☐ HEAD & SHOULDERS TIRED & HEAVY
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATION
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN/STIFFNESS
- ☐ MID BACK PAIN/STIFFNESS
- ☐ LOW BACK PAIN/STIFFNESS
- ☐ PINS & NEEDLES IN ARMS/LEGS
- ☐ NUMBNESS IN FINGERS, ARMS, LEGS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ EYES LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EARS BUZZING/RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ INSOMNIA
- ☐ NEURITIS
- ☐ FACE FLUSHED
- ☐ FACE PALE
- ☐ EXCESS PERSPIRATION
- ☐ DIGESTIVE DISORDERS
- ☐ NAUSEA, VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ SWOLLEN _____
- ☐ FEET/HANDS COLD
- ☐ DIFFICULTY IN PROLONGED CAR RIDING

☐ DIFFICULTY IN EXCESSIVE ☐ STANDING ☐ WALKING ☐ RIDING ☐ BENDING

☐ NECK, LOW BACK PAIN & STIFFNESS UPON RISING.

☐ PAIN RADIATING INTO ☐RIGHT ARM ☐ RIGHT LEG ☐ BOTH ☐ LEFT LEG ☐ LEFT ARM ☐ BOTH

☐ DIFFICULTY IN EXCESSIVE LIFTING. ☐ LIGHT ☐ MODERATE ☐ HEAVY ☐ REPETITIVE

☐ PAIN RADIATING INTO ☐ NECK ☐ BASE OF SKULL ☐ SHOULDER ☐ ARMS ☐ HIPS ☐ LEGS

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF SO, WHERE? _____

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO

SYMPTOMS OTHER THAN ABOVE _____

_____

INSURANCE COMPANIES INVOLVED

INSURANCE COMPANY OF PARTY RESPONSIBLE FOR PAYMENT _____ CLAIM # _____

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER OR COMPANY REPRESENTATIVE ABOUT CLAIM? _____

HAS YOUR ATTORNEY ADVISED YOU IN THIS CASE? ☐ YES ☐ NO

ATTORNEY'S NAME, ADDRESS & TELEPHONE # _____

PATIENT'S SIGNATURE _____ DATE _____

BODY THERAPEUTICS

WERE YOU REFERRED TO A CERTAIN DOCTOR AT THIS CLINIC? IF SO, WHO? _____

WHO REFERRED YOU? _____

IS YOUR VISIT DUE TO AN ACCIDENT? ☐ YES ☐ NO (IF YES, PLEASE COMPLETE BOTH SIDES.) WORK PHONE (___) _____

PATIENT DATA

NAME _____ HOME PHONE (___) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYED BY _____ SS # _____

NAME OF NEAREST RELATIVE _____ PHONE NUMBER (___) _____

NAME OF WIFE OR HUSBAND _____ DRIVER LIC # _____ OCCUPATION _____

EMPLOYER _____ ADDRESS _____ PHONE # _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS _____

_____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION _____

MEDICAL HISTORY (If any of the following are relevant to your medical history, please check the accompanying box.)

☐ CANCER	☐ MUSCULAR DYSTROPHY	☐ RHEUMATIC FEVER
☐ POLIO	☐ MULTIPLE SCLEROSIS	☐ SCARLET FEVER
☐ TUBERCULOSIS	☐ CONVULSIONS	☐ NERVOUSNESS
☐ HIGH BLOOD PRESSURE	☐ EPILEPSY	☐ ASTHMA
☐ HEART TROUBLE	☐ CONCUSSION	☐ DIGESTIVE DISORDERS
☐ DIABETES	☐ DIZZINESS	☐ SINUS TROUBLE
☐ HEPATITIS	☐ ARTHRITIS	☐ BACKACHES
☐ GERMAN MEASLES	☐ NEURITIS	☐ NUMBNESS
☐ VENEREAL DISEASE	☐ RHEUMATISM	☐ ANEMIA

DESCRIBE THE OPERATIONS YOU'VE HAD: _____ WHEN? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ YES ☐ NO _____

DESCRIBE CONDITION _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

ARE YOU PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD _____

INSURANCE DATA (Clinic policy requires payment arrangements be made on the first visit.)

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____ PHONE NO. (___) _____

DO YOU HAVE INSURANCE? ☐ YES ☐ NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____

SPOUSE'S INSURANCE _____

WORKER'S COMPENSATION _____

OTHERS _____

EMPLOYEE I.D. NO. _____
POLICY NO. _____
GROUP NO. _____
MEDICARE NO. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

If yours is an accidental injury, please complete the reverse side of this form as well.

Practice Systems – 1988, Scottsdale, AZ

BODY THERAPEUTICS

AUTO ACCIDENT / PERSONAL INJURY / WORKER'S COMP INSURANCE FORM

Patient Name: _____ Date:_____

Name of Guardian (if minor): _____

Name of Insurance Company: _____

Insurance Co. Address (PIP carrier): _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone Number: _____

Insurance Co. Fax Number: _____

Date of Injury or Accident: _____

Claim #: _____

Adjuster's Name: _____ Phone #: _____

ATTORNEY INFORMATION

Attorney Name: _____

Law Office Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Patient's Signature: _____ Date:_____

102 Shore Drive No 104 – Worcester, MA 01605
P: 508.853.7500 F: 508.853.7505
www.body-therapeutics.com

BODY THERAPEUTICS

HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c.90, Section 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below. Thank you very much.

1. Are you eligible for health coverage under any Health Insurance Plan? ____ **Yes** ____ **No**

   A. If **Yes**, please answer the following questions. This information can be found on your health insurance card.

   Name of Plan: _____
   Policy No: _____ Group Plan No: _____
   Plan Telephone No: _____
   Address for Claims: _____

   If you are not the subscriber to the plan, please complete the information below:

   Subscriber Name: _____
   Subscriber SSN: _____ Subscriber Date of Birth: _____
   Street Address of Subscriber: _____
   City, State, Zip _____
   Subscriber Phone #: _____ Relationship to you: _____

   B. If No, are you eligible for coverage under any government program? __ **Yes** __ **No**

2. MVA Insurance Info:

   Name of Plan: _____
   Policy No: _____ Claim No: _____
   Adjustor Name: _____ Phone: _____

Applicant's Signature: _____ Date: _____

102 Shore Drive No 104 – Worcester, MA 01605
P: 508.853.7500 F: 508.853.7505
www.body-therapeutics.com