HOFFMAN CHIROPRACTIC NEUROLOGY
PERSONAL INJURY / WORKMAN COMPENSATION CASE HISTORY
CONFIDENTIAL PATIENT INFORMATION

Date_____Name:_____ _____Middle Initial_____

Address:_____City_____State_____Zip_____

Phone:_____Cell:_____ Work #:_____Email:_____

SSN:_____DOB:_____Marital Status: M S D W Number of Children:_____

Employer:_____Occupation:_____

Attorney Name:_____Phone:_____

AUTO/TRUCK/OTHER TYPE OF ACCIDENT ONLY

Date of Accident:_____Approx. speed of vehicle you were in:_____

Were you: Driver Passenger Front seat Back seat Wearing a seat belt? YES NO Number of passengers:_____

Were you struck from: Behind Front Left Side Right Side Were you knocked unconscious? YES NO

Were police notified: YES NO Were you taken to the hospital? YES NO Do you have a police report? YES NO

Your Auto Insurance Company:_____ _____Policy:_____

Phone:_____ Agent:_____Have you contacted them: YES NO

WORKMAN'S COMPENSATION ACCIDENTS ONLY

Date of Accident:_____ Did you report the accident that day? YES NO

To whom was the report made?_____Name of contact person_____

ALL PATIENTS ANSWER THE REST OF THE QUESTIONS

In your own words, please describe the accident:_____

_____

_____

Please describe how you felt:
DURING THE ACCIDENT:_____
IMMEDIATELY AFTER:_____
CURRENT:_____

Did you have any physical complaints BEFORE THE ACCIDENT? YES NO If yes, please describe:_____
_____

Do you have any previous illnesses which relate to this case? _____
Have you been treated by another doctor since the accident? YES NO If YES, Name of Doctor_____
What type of treatment have you received?_____
Were XRAYS taken: YES NO Have you lost any time from work as a result of this accident: YES NO

PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing?

   _____

   _____

2. If this is a re-occurrence, when did you originally notice the problem?
   What initially caused it?

   _____

3. Has it changed recently?_____ Better ____ Worse _____ Same What types of treatment have you tried?

   _____

   _____

   What makes it better? _____ Worse? _____

4. How frequent is the condition?_____ How long does it last?_____

5. Is this affecting your sleep?_____ Yes ____ No If yes, please describe:

   _____

   _____

6. Is this affecting your ability to perform your job or daily activities?____ Yes ___ No if yes, please describe:

   _____

7. Are there any other symptoms that may be related to these concerns, which you have not listed?
   _____Yes _____ No
   If yes, please describe: _____

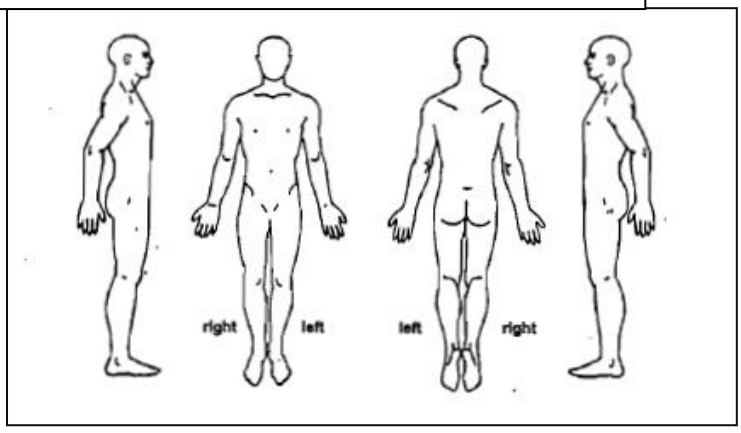
Please mark an "X" on the line to indicate the severity of your condition:

No symptoms — Extreme symptoms
Does not interfere with activities — Disabling

1_____10

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



Because of the nature of Personal Injury and Workman's Compensation regulations, it is extremely important to maintain your treatment schedule. If you miss your scheduled appointment & fail to reschedule that appointment later on that same day, there will be an "office visit" fee charged to your insurance carrier.

Please note that the bills for services will be submitted to your insurance company or responsible party and/or attorney. Please be aware that once your attorney has signed an Attorney's Lien form, indicating that our bill will be protected, then we will honor this agreement & allow for payment to be made upon settlement of your claim. However, should you decide to terminate your treatments, before you have been released by Dr. Hoffman, then your entire bill will become due and payable within 10 days following the date of your last visit.

LEGAL ASSIGMENT OF BENEFITS AND RELEASE OF MEDICAL & PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Hoffman Clinic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature_____Date_____

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