Case History(Auto/Work)

Today's Date:_____

GENERAL INFORMATION

Patient Name:_____ Cell Phone: (_____)_____Carrier: AT&T / Sprint /_____

Home Phone: (____)_____ e-mail address or alt phone :_____

Address:_____ City:_____ State: _____ Zip:_____

Age:_____ Date of Birth: ____/____/____ Sex: Male - Female Social Security #:_____/____/_____ Drivers Lic #:_____

Marital Status: S / M / D / W Which hand do you write with?: R / L / Both Ht:_____ Wt:_____lbs. Spouse's Name:_____

Employer's Name:_____ Work Phone: (_____)_____

Nature of Business/Employment:_____

Employers Address:_____ City:_____ Zip:_____

Occupation: (Job Title)_____ Length of Employment: _____yrs. _____mo.

Date last worked:_____ Employment Status: Full / Part / _____ Number of hours worked per week:_____hrs/wk.

Spouse's Occupation:_____ Number of Children:_____ Ages:_____

Name of Emergency Contact:_____ Phone: (_____)_____

Who or How Were You Refered to This Office:_____Who is responsible for your account?_____

Reason / Purpose of This Appointment:_____

Other Doctors Seen for This Condition:__MD __DC __DO __DDS Names:_____

Diagnosis:_____ Other Tests: __X-rays __MRI __CT __Blood Work __Urinalysis __Other:_____

Treatment: Medications:_____ Physiotherapy:_____ Other:_____

Results:_____ Length of time under care: _____Yrs _____Months - Frequency of Visits:_____

Are you currently taking any medications either prescribed or over the counter: __No __Yes:_____

When Did This Condition Begin / Date of Injury: _____/_____/_____ Were You Disabled From Work: __NO __YES

When did your disability begin? **_____/_____/_____** What was the last day you worked? **_____/_____/_____**

If so, how long? _____Yrs _____Months Have you returned to your same job? __No __Yes If yes, when?_____

SOCIAL HISTORY

Education: _____Grade _____Yrs. Coll List Your Hobbies and How Often You Do Them:_____

_____

Coffee_____ cups/day Tea_____ cups/day Soda/Cokes_____ cans/day Cigarettes_____ pack/day How Many Years_____

FAMILY HISTORY

	Age	Current state of health	Living/Deceased	Age	Current state of health	Living/Deceased
Mother:	_____	_____	_____	Father: _____	_____	_____

Family History: List any conditions that your mother, father or any other relative has had which may include but is not limited to: Arthritis, Diabetes, Cancer, Heart Disease, Hypertension, Peptic Ulcer, Tuberculosis, Ankylosing Spondylitis, Multiple Sclerosis, Etc.

_____

TURN PAGE AND CONTINUE.....

PAST MEDICAL HISTORY

Have you ever had? __Sugar Diabetes __Tuberculosis __Heart Disease __High Blood Pressure __Lung Disease __Intestinal Problems
__Kidney or Bladder Disease __Cancer =>type:_____ Other serious Illness:_____

Have you ever had any other accidents prior to this injury, if so list dates: (including auto, sports, injuries/accidents around the home or at work, also list any broken bones):

_____

Allergies:__NONE __Asprin __Tetanus Toxiod __Tetracycline __Codine __Penicillan __Dusts __Cats __Pollen __Grass __Foods
__Other:_____

List all surgeries and hospitalizations from birth up to today:_____

_____

INJURY / ACCIDENT INFORMATION

Cause of Injury:__Vehicle __Work __Slip/Fall __Sports Injury __Assault __Continuous Trauma __Other:_____

Describe in your own words, how the accident or injury occurred:_____

_____

_____

_____

_____

What is your major complaint?_____

How long have you had this condition?_____ Have you had this or similar conditions in the past?__No __Yes

What activities aggravate your condition/s? __Standing too long __Sitting too long __ Lying on my back __Lying on my stomach __Driving __Sneezing __Coughing __During sex __After sex __Bowel movements __Pushing __Pulling __Bending __Stooping __Vacuuming __Lifting over _____lbs. __Walking long distances
Other:_____

Is this condition getting progressively worse? __No __Yes __Constant __Comes and goes Other:_____
Is this condition interfering with your: __Work __Daily routine __Attitude __Mood __Sleep => it wakes me ____ times per night.

Prior to the injury I normally slept _____hrs each night. Now after the injury I sleep _____hrs a night. I fall asleep around _____

All Complaints / What parts of your body were injured; list area in order of severity, Intensity and Duration as follows:
Intensity of pain from 0-10; 1=Annoying and 10=Unbearable
Duration of pain, Constant= 100% of time, Frequent = 75% of time, Intermittent = 50% of time, Occasional = 25% of the time or less
Describe the quality or sensation of the pain in your own words (Ex. numbness, aching, throbbing, burning, pins & needles, stinging.)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

TURN PAGE AND CONTINUE.....

Other complaints: __Difficulty chewing __Insomnia __Headaches __Double vision __Constipation __ Reduced hearing __Weight loss
__Eyes sensitive to light __Nervousness __Tension __Lightheaded __Ringing in ears __Diarrhea __Extreme fatigue
__Reduced appetite __Weight gain __Weight loss __Abdominal pain __Dark black stool __Bright red stool __Coughing
__Restlessness __Depression __Dizziness __Excessive sweat __Dry mouth __Bloating __Blurred vision __Nausea
__Poor memory __Vomiting __Difficulty swallowing __Difficulty breathing __Blood in urine __Pain on urination
__Sinus problems __Menstrual irregularity __Vaginal pain/infections __Breast pain/lumps __Prostate/Sexual dysfunction
__Excessive thirst __Cold extremities __Ankle swelling __Asthma
Other:_____

Did you lose consciousness? __No __Yes: __Few seconds __1 minute __ 5 minutes __10 minutes __Other:_____

Was a police report taken? __No __Yes Did you notifiy your supervisor? __No __Yes

How did you feel immediately after the injury? __Dazed __Shocked __Shakey __Lightheaded __Jittery __Scared __Nervous __Stunned
__Confused __Dizzy __Nauseated __Panicky __Other:_____

Did you have any __Fractures __Cuts __Abrasions __Bruises If so, where:_____

Where did you develop pain immediatly after the injury?_____

_____

Did you develop pain or did the pain increase later? __No __Minutes later __Hours later __That evening __The following morning
__A few days later __A week/weeks later __A month later __Months later

Where did the pain increase or where did you develop the pain?_____

_____

_____

_____

_____

Who administered care at the scene of injury?__Nobody __Paramedics __The Police __A bystander __A friend/family member __Doctor
Were you taken to the hospital?__No __Yes (How did you get there) __Ambulance __Family __Friend __Drove myself __Other:_____

Hospital Name:_____ Treating Physician:_____

What was done for you at the hospital? (Write all treatment that was done and list x-rays if they were taken.)

_____

_____

Were you admitted? __No __Yes Discharge date:_____ Was medication perscribed? __No __Yes:_____

Have you had any other personal injury or accident? __Past year __Past 5 years __Over 5 years ago __None Other:_____

Describe any previous personal injuries:_____

INJURY / ACCIDENT INFORMATION (FOR VEHICLE ACCIDENT ONLY)

How many people besides yourself were in the car? _____ => Ages of other passengers:_____

What type of vehicle were you driving?

__Car __Van __Station Wagon __Small Pickup Truck __Full Size Pickup __Motorcycle __Bicycle Other:_____

Where were you seated?

__Driver __Right Front __Middle Front __Right Rear __Middle Rear _Left Rear Other:_____

How was your vehicle struck?

__Rear-Ended __Struck Head On __Struck From The Right __Struck From The Left __Sideswiped on the __LEFT __RIGHT

What type of vehicle struck you?

__Car __Van __Station Wagon __Small Pickup Truck __Full Size Pickup __Motorcycle __Bicycle Other:_____

The damage to the vehicle that you were in was:__Slight __Moderate __Severe __Totaled What was the damage amount? _____

How was the vehicle removed from the scene? __I Drove the vehicle away myself __Driven away by someone else __Towed away

TURN PAGE AND CONTINUE.....

What was your position at the time of the accident? (Check all that apply)
__I Saw The Other Vehicle Coming __Unprepared __Braced For The Impact __Holding The Steering Wheel
__Tightly Gripping The Steering Wheel __Stepping Hard On The Brakes Looking To The: __Left __Right __Straight Ahead

How did your body move?
__Forward & Backward __Backward & Forward __Throughout The Vehicle __Outside The Vehicle __Under The Vehicle
__Sideways Other:_____

How did your head move?
__Sideways __Forward & Backward __Backward & Forward __Forward __Backward Other:_____

Were you wearing a seatbelt? __No __Yes => Type __Lap Belt Only __Lap & Shoulder Belt __Harness Other:_____

What parts of your body struck the vehicle? (List the body part and what it struck against)

_____

INSURANCE / ATTORNEY INFORMATION

Have you retained an Attorney?__No __Yes Do you have auto insurance?__No __Yes Do you have medical insurance?__No __Yes

Name of insured:_____ S.S. # of Insured:_____

Insureds Date Of Birth: _____/_____/_____ Insured Employers Name / Phone:_____(___)_____

Insured Employers Address:_____ City:_____ State: _____ Zip:_____

Name And Address Of Insurance Carrier:_____Agent:_____

Telephone Number of Insurance Company: (____)_____ Group #:_____ Policy / Claim #:_____

Attorney's Name:_____ Phone Number: (_____)_____

Attorney's Address:_____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. If a check goes to the Doctor's Office with my name on the check, I authorize Power of Attorney to sign my name so that the check can be deposited and credited to my account. However, I clearly understand and agree that all services rendered to 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, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Person or Persons Assisting Patient:_____ Date:_____

Thank you!! And again, we look forward to a healthy relationship with you.

NOTICE OF DOCTOR'S LIEN

Patient:_____

Date of Accident:_____

I do hereby authorize ***Jonathan R. Hoops, D.C.*** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not wait payment but may declare the entire balance due and payable.

Dated:_____ _____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated:_____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: ***Jonathan S. Hoops, D.C.***
235 N. Euclid Street
Fullerton, CA. 92832
(714) 526-9355 Tel
(714) 526-9350 Fax

ASSIGNMENT AND INSTRUCTION OF BENEFITS FOR DIRECT PAYMENT TO THE DOCTOR FOR PRIVATE / GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct _____
Insurance Company to pay by check made out and directly mailed to:

JONATHAN R. HOOPS, D.C.
235 N. Euclid Street
Fullerton, CA. 92832-1621
(714) 526-9355 Tel (714) 526-9350 Fax

- OR -

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make check payable to me in conjunction with the doctor and mail it as follows:

C/O: JONATHAN R. HOOPS, D.C.
235 N. Euclid Street
Fullerton, CA. 92832-1621

The professional or medical expense benefits allowable and other wise payable to me under my current insurance policy as payment toward charges for professional services rendered. ***THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY***. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at Fullerton, CA. this _____ day of _____, 20_____.

_____
Signature of Policyholder

_____
Signature of Claimant, if other than Policyholder

_____
Witness

HOOPS CHIROPRACTIC CORP.
Jonathan R. Hoops, D.C.
235 N. Euclid Street
Fullerton, CA. 92832
(714) 526-9355 Tel
(714) 526-9350 Fax

RE: NOTICE OF DOCTOR'S LIEN

Insured:

Claim No.:

Date of Loss:

Patient:

I do hereby authorize Hoops Chiropractic Corp. or Dr. Jonathan R. Hoops, D.C. to furnish you with a full report of my examination, diagnosis, treatment, prognosis, billing, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to myself, as the result of the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ _____
Patient's Signature

Dated: _____ _____
Doctor's Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE – "AOR"

What is HIPAA Administrative Simplification?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. In a nutshell, we are ordered to make sure all possible measures are in place in order to protect your medical information here in this office. Your medical file / information will not be given out to anyone without your consent. Other forms of protection are also implemented in order to protect your privacy as outlined in the **"NOTICE OF PRIVACY PRACTICES."**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hoops Chiropractic's "NOTICE OF PRIVACY PRACTICES," revision dated Jan 1st, 2022.

As required by the Privacy Regulations, Hoops Chiropractic has explained the **"NOTICE OF PRIVACY PRACTICES," to my satisfaction.**

As required by the Privacy Regulations, I am aware that Hoops Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

I acknowledge that I received a copy of *Hoops Chiropractic* **"NOTICE OF PRIVACY PRACTICES," revision dated Jan 1st, 2022.**

Patient name (print)_____

Signature _____ Date _____

Signed form received by:_____ Date:_____

If Patient Refuses to sign place an "X" on this line:_____

Hoops Chiropractic
235 N. Euclid St.
Fullerton, CA. 92832
714-526-9355

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments, massage and other chiropractic procedures, including various modes of physiotherapy including massage therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Hoops Chiropractic

I understand that, as in the practice of medicine, in the practice of chiropractic care and massage there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Hoops Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Date

_____

Patient or Guardian's Signature

STOP

You Are Finished ☺

Return Forms to the Front Desk