Gaithersburg Wellness Center

Dr. Sangbum Joo, D.C., M.S.

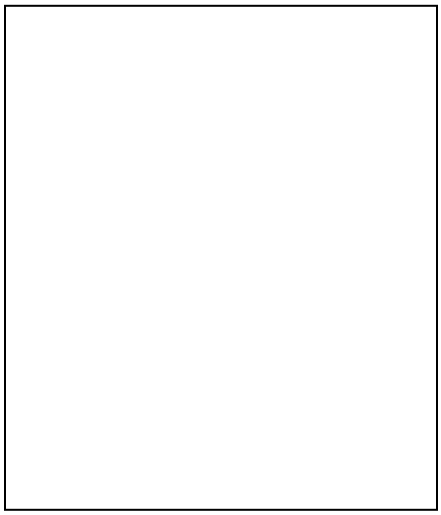
Confidential Patient Health Record

Last Name/First Name/ Middle Initial: _____ Date: _____
Home Ph#: _____ Cell Ph#: _____ Work Ph#: _____
Email Address: _____
Street Address: _____
City/State/Zip Code: _____
Date of Birth: _____ Age: _____ Social Security#: _____
Sex: ☐Male ☐Female Status: ☐Married ☐Single ☐Widowed ☐Divorced/Separated
Occupation at the Time of Accident:_____
Employer: _____
Are You Currently Unemployed Due to Accident? ☐YES ☐NO
Type of Work: ☐Office/Clerical ☐Light Labor ☐Moderate Labor ☐Heavy Labor
Driver's License #:_____ State: _____
In Case of Emergency, Please Contact (Please Include Name, Phone #, and Relationship):
_____

GENERAL ACCIDENT HISTORY:
Date of accident: _____ Time: _____AM / PM
On what street or intersection did the accident occur? _____ City/State:_____
Was the accident on the job? YES / NO
You were: ☐Driver ☐Front Seat Passenger ☐Rear Seat Passenger ☐Motorcycle Passenger
☐Motorcycle Operator ☐Other: _____
Vehicle driven by: _____
What type of vehicle were you in? (Year & Model)_____
What type of vehicle impacted yours? (Year & Model of other car)_____
Your estimated speed at moment of accident: _____ ☐Stopped ☐Slowing ☐Accelerating
The other vehicles speed at the moment of accident: _____☐Stopped ☐Slowing ☐Accelerating
What type of impact was the auto accident? (Check all that apply) ☐Head-on Collision ☐Front Impact
☐Broad-side Collision ☐Rear-end car in front of you ☐Rear impact ☐Non-collision
Road Conditions: ☐Dry ☐Rainy ☐Wet ☐Snow ☐ Clear ☐Dark ☐Icy ☐Other:_____
Visibility at the time of the accident: ☐Poor ☐Fair ☐Good ☐Other:_____
Where was the headrest positioned on your head? ☐Up ☐Down ☐Don't know
Was the seat broken? ☐YES ☐NO
Did you have your seatbelt on during the accident: ☐ Yes ☐No
Did air bag deploy? ☐YES ☐NO If yes, were you struck? ☐YES ☐NO
How was your body positioned during the accident? _____
How was your head positioned during the accident? _____
Hands: ☐One on wheel Two on wheel ☐N/A _____
Did you apply your own brakes? ☐YES ☐NO

Accident description: (Be specific)_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ACCIDENT DIAGRAM:



DURING THE ACCIDENT
Did you know the accident was coming? ☐YES ☐NO
Did you strike any parts of the vehicle? ☐YES ☐NO
If yes, describe: _____
During and after the crash what happened to your vehicle? (Check all that apply)
☐Kept going straight ☐Spun around ☐Kept going straight hitting a car in front
☐Hit a stationary object ☐Spun around &hit a stationary object
☐Was hit by another vehicle ☐Other _____
Did your vehicle hit anything following the accident? ☐YES ☐NO
If yes, describe: _____
_____
Wearing hat or glasses? ☐YES ☐NO
If yes, were they still on after the accident? ☐YES ☐NO _____
Did you lose consciousness? ☐YES ☐NO
If yes, for how long? _____
Did you get any bleeding cuts? ☐YES ☐NO

Did you get any bruises? ☐YES ☐NO
Are you pregnant? ☐YES ☐NO If yes, how far along? _____
Estimated property damage to your vehicle: $ _____
Estimated damage to other vehicle(s): ☐None ☐Minimal ☐Moderate ☐Major
Were the police on the scene? ☐YES ☐NO
If yes, was a report made? ☐YES ☐NO

AFTER THE ACCIDENT:

Where did you go after the accident? ☐Hospital_____ ☐Urgent Care_____
☐Home ☐Work ☐Other _____
If you answered Hospital or Urgent Care, please specify day and time: _____
How did you get to the hospital? ☐Ambulance ☐Drove self ☐someone else drove ☐Other:_____
Did you stay in the hospital overnight? ☐Yes ☐No
Did you receive the following in the hospital: ☐Pain medication ☐Muscle relaxer ☐Neck brace
☐stitches ☐MRI ☐Examination ☐X-rays ☐CAT scan ☐Cast ☐Other _____
Who was the first doctor that treated you?
Name:_____
Date seen:_____
Were you examined? ☐Yes ☐No
Were x-rays taken? ☐Yes ☐No Were you: ☐Sitting ☐laying down ☐Standing
If x-rays were taken, what areas of the body were x-rayed?_____
Did you receive treatment? ☐Yes ☐No
If yes, what kind of treatment did you receive?_____
_____
What benefits did you receive from the treatment? _____
_____

I hereby authorize Dr. Joo to examine me, including X-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO JU CHIROPRACTIC WELLNESS CENTER FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

_____ _____
Signature of Patient, or of Guardian Authorizing Care Date

101 LAKEFOREST BLVD. STE. 395 GAITHERSBURG MD 20877 PHONE: 301-200-8060 FAX: 301-200-8360