

Automobile/Personal Insurance Accident or Work Comp Questionnaire

About this Patient

First Name

Middle Name:

Last Name

Street Address

City

State/Province

Zip Code

Cell Phone

Gender

Female

Male

Number of Children

Birthday

Employer

Work City

Work State

Type of Work

Marital Status

Married

Single

Email

Social Security #

About the Spouse

First Name

Last Name

Employer

Work Phone

Type of Work

Emergency Contact

First Name

Last Name

Relationship

Cell Phone

Information about the Accident / Present Injury

Please explain in detail how your accident happened:

Were you knocked unconscious

Yes No

You were struck from:

Behind Front
 Left side Right side

You were:

Driver Passenger
 Back seat - left Back seat - right
 Using seat belts

What was the time and date of present injury?

Where did you feel pain immediately after the accident?

List the extent of your injuries as you know them:

Did you require post-accident hospitalization?

Yes No

Where were you taken after the accident?

Were you hospitalized?

Yes No

If hospitalized, were you admitted?

Yes No

If admitted, for how long?

What treatment was given?

Was any doctor consulted after your accident?

Yes No

If so, what was the doctor's name?

What was the diagnosis?

What treatment was given?

How frequently did you see the doctor?

How long did you see the doctor?

Have you ever had any complaints in the involved area before?

Yes No

If so, what were the complaints?

Before the injury were you capable of working on an equal basis with others your age?

Yes No

Are your work activities restricted as a result of this accident?

Yes No

Since this injury are your symptoms are:

Improving Getting worse Same

Insurance Information

Driver of other vehicle (if any):

First and Last Name

Insurance Company

Claim No.

Driver of vehicle in which you were injured (if applicable):

First and Last Name

Insurance Company

Claim No.

Name of your insurance adjustor:

Adjustor Email or Phone #:

Adjustor Fax #:

Have you retained an attorney?

Yes

No

If yes, what is their name?

If so, what is their email or phone #?

If so, what is their fax #?

Outcome Assessment

Check symptoms you have noticed since the accident:

Headache

Light Bothers Eyes

Head Seems to Heavy

Pins and Needles in Arms

Sleeping Problems

Pins and Needles in Legs

Numbness in Fingers

Numbness in Toes

Shortness of Breath

Dizziness

Buzzing in Ears

Memory Loss

Ears Ring

Back Pain

Constipation

Loss of Smell

Loss of Taste

Stomach Upset

Depression

Diarrhea

Feet Cold

Hands Cold

Face Flushed

Tension

Fever

Chest Pain

Fatigue

Neck Pain

Neck Stiff

Fainting

Loss of Balance

Nervousness

Irritability

Cold Sweats

Symptoms other than above:

Using the scale below for reference, please answer the following questions as accurately as possible

What is the pain level of your primary complaint RIGHT NOW? (0-no pain; 10-worst possible pain)

What is the TYPICAL/AVERAGE pain of your primary complaint? (0-no pain; 10-worst possible pain)

What is the pain level of your primary complaint AT ITS BEST? (0-no pain; 10-worst possible pain)

What is the pain level of your primary complaint AT ITS WORST (0-no pain; 10-worst possible pain)?

When did this condition begin?

Overall frequency of complaint (Please check only one)

Constant - 100% of the time Frequent - 75%

Intermittent - 50%

Occasional - 25%

Is this problem affecting any other area of your body? If yes, please explain:

Does it interfere with your normal daily activities (Family, recreation, sports)?

Do your symptoms increase while performing your normal work duties?

Yes No

If yes, please select the amount below that you feel your symptoms increase at work:

0% 10% 20% 30%
 40% 50% 60% 70%
 80% 90% 100%

What aggravates the problem?

What relieves the problem?

Please explain.

Has this condition

Gotten worse Stayed Constant Comes and goes

Does this condition interfere with

Work Sleep
 Daily Routine Other activities

Has this condition occurred before?

Yes No

Explain

Have you seen other doctors for this condition?

No Yes

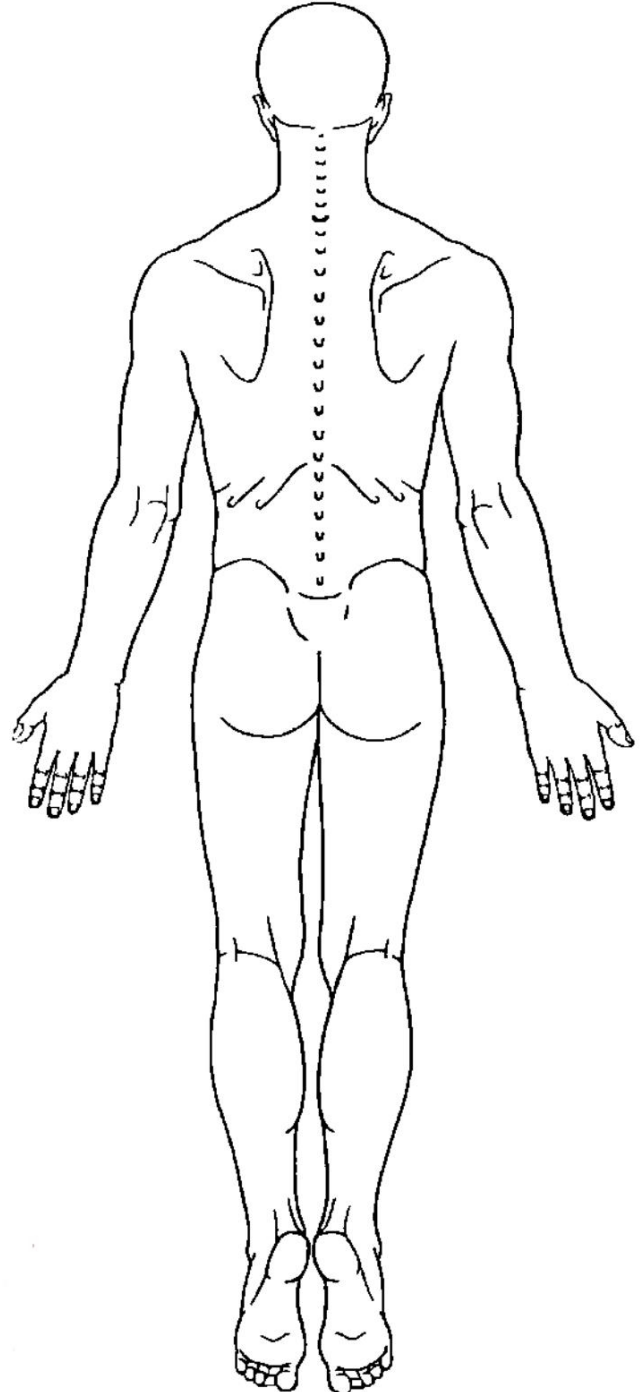
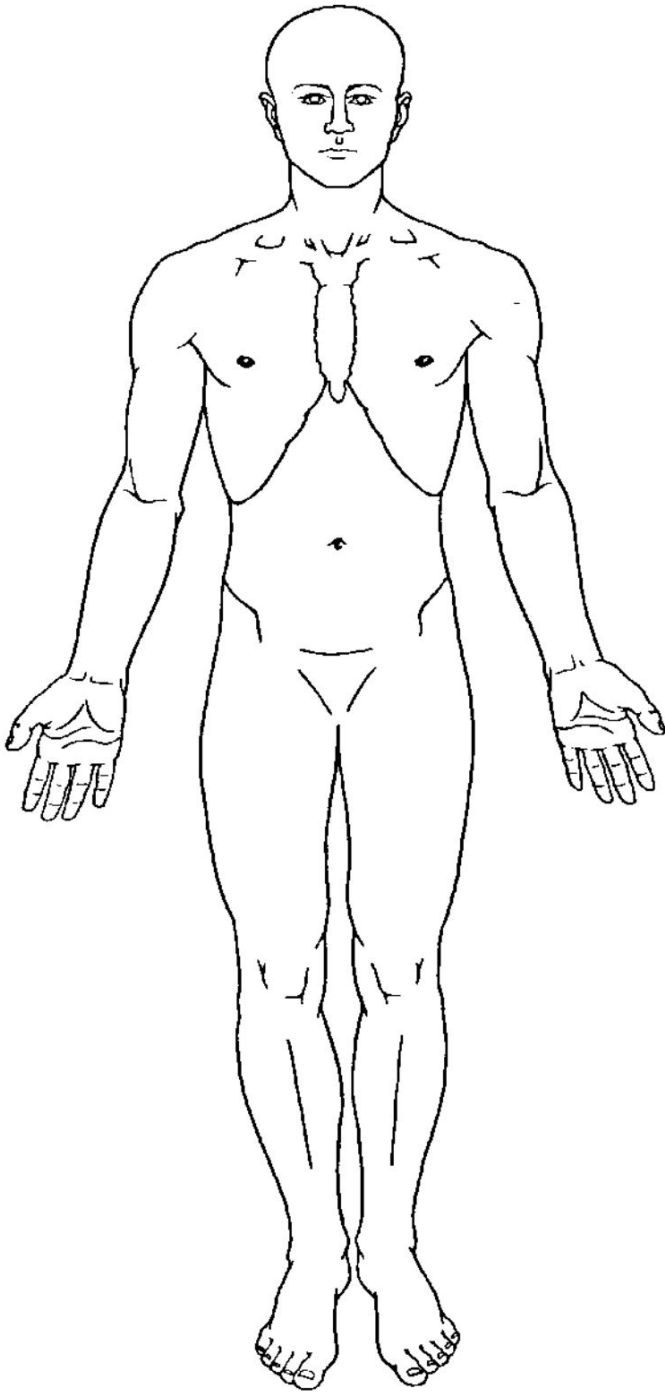
Doctor's Name (s)

Type of Treatment

Results

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Please list approximate dates of past car/auto accidents:

Complications / Injuries from the accident(s):

Previous Surgeries / Hospitalizations:

Additional Notes:

Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Going from Sitting-to-Standing

- | | |
|---|--|
| <input type="checkbox"/> No Effect / Sin efecto | <input type="checkbox"/> Painful (can do) / Doloroso (puedo hacer) |
| <input type="checkbox"/> Painful (limits) / Doloroso (limitado) | <input type="checkbox"/> Unable to Perform / No puedo Realizar |

Climbing Stairs

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Driving

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Extended Computer Use

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Getting Dressed

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Lifting Children/Groceries

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Sexual Activities

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Sleep

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Static Sitting

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Static Standing

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Walking

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Washing/Bathing

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Yard Work

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Experience with Chiropractic

Have you been adjusted by a chiropractor before?

- Yes No

Reason for those visits?

Doctor's Name

Approximate date of last visit?

Has any adult in your family seen a Chiropractor?

- Yes No

Has any child in your family seen a Chiropractor?

- Yes No

Awareness of Chiropractic Principles

Were you aware that...

Doctors of Chiropractic work with the nervous system?

- Yes No

The nervous system controls all bodily functions and systems?

- Yes No

Chiropractic is the largest natural healing profession in the world?

- Yes No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

- Yes No

Goals for my Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

- Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

- Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

- Yes

Medications I Now Take:

Nerve Pills

Pain Killers (including Aspirins)

Muscle Relaxers

Blood Pressure Medicine

Insulin

Stimulants

Blood Thinners

Tranquilizers

Other medications not listed in the previous section:

Health Habits

Do you smoke or vape?

- Yes No

Do you drink alcohol?

- Yes No

Do you exercise regularly?

- Daily Moderately No

Do you drink coffee?

- Yes No

Health Systems Review

Please check each of the conditions that you have experienced within the past 6 months.

Health Conditions:

- | | |
|---|--|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Frequent Neck Pain |
| <input type="checkbox"/> Numbness in Arms/Legs/Hands | <input type="checkbox"/> Lower Back Problems |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Anemia | |

Is there any other health condition that you'd like the doctor to know about?

FOR WOMEN ONLY:

Are you pregnant?

- Yes No

Are you nursing?

- Yes No

Do you have irregular cycles?

- Yes No

Are you taking birth control?

- Yes No

Do you experience painful periods?

- Yes No

The first day of my last menstrual cycle was on (date):

Nutrition and self-care are just two components of optimal wellness.

Please let us know what you are currently doing for your health.

Things I do currently to support my health include:

- | | |
|---|--|
| <input type="checkbox"/> Drink plenty of water | <input type="checkbox"/> Exercise regularly |
| <input type="checkbox"/> Get plenty of rest | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Pray/Meditate | <input type="checkbox"/> Yoga/Pilates/Aerobics |
| <input type="checkbox"/> Alcohol in moderation | <input type="checkbox"/> Homeopathic remedies |
| <input type="checkbox"/> Maintain positive attitude | <input type="checkbox"/> Self-improvement books |
| <input type="checkbox"/> Eat organically grown foods | <input type="checkbox"/> Vitamins, minerals or herbs |
| <input type="checkbox"/> Maintain the proper weight | <input type="checkbox"/> Receive regular massages |
| <input type="checkbox"/> Counseling/Therapy | <input type="checkbox"/> Orthotics/Heel Lifts |
| <input type="checkbox"/> Use a cervical pillow | <input type="checkbox"/> Attend religious services |
| <input type="checkbox"/> Annual physical examinations | |

On average, how many hours do you spend sitting per day?

- 0-3 4-6 7-8 9-12 12+

Please list any vitamin supplements you are currently taking

Authorization for Care & Notice of Privacy

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers' compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost. Your signature below gives us permission to send your medical records and x-rays to you on an encrypted server to the email that you provide to us.

COMPLAINTS:

I have received a copy of the Privacy Notice I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at a time in the future and will make the new provisions effective for all information that it maintains past and present.

Informed Consent to Chiropractic Care:

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between once per one million to one per two million, have been associated with chiropractic adjustments.

I understand there may be treatment options available for my condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Consent for Diagnostic X-rays:

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment.

Females Only:

- I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.
- I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.
- By my signature below I am acknowledging the risks of hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

Please select one of the following:

- To the best of my knowledge, I am not pregnant / Hasta donde yo sé, no estoy embarazada.
- I think I may be pregnant / Creo que puedo estar embarazada
- I am pregnant / Estoy embarazada

Signature

Date Signed

Printed Name

Email

Guardian or Spouse's Signature (if applicable)
