

Life Chiropractic

Personal Injury Questionnaire

Name _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? Yes No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of day _____

2. Were you: Driver Passenger Front Seat Back Seat

Does your car have headrest? Yes No If yes, what height was it at time of impact:

bottom of neck bottom of head middle of head

3. Number of people in vehicle? _____ Were you wearing seat belts? _____

4. What direction were you headed? North East South West

5. What direction was other vehicle headed? North East South West

6. Were you struck from: Behind Front Left side Right side

7. Approximate speed of your car? _____ mph Other car _____ mph

8. Were you knocked on unconscious? Yes No If yes, how long? _____

9. Were police notified? Yes No

10. In your own words, please describe accident:

11. Did you have any physical complaints BEFORE THE ACCIDENT? Yes No If yes, please describe in detail:

12. Please describe how you felt:

- a. DURING the accident: _____
- b. IMMEDIATELY AFTER the accident: _____
- c. LATER THAT DAY: _____
- d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

14. Do you have any congenital (from birth) factors which relate to this problem? Yes No If yes, please describe:

15. Do you have any previous illnesses which relate to this case? Yes No If yes, please describe:

16. Have you ever been involved in an accident before? Yes No If yes, please describe, including date(s) and types(s) of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? Yes No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms: Improving Getting worse Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? Yes No If yes, please complete this question.

- a. Last Day Worked: _____
- b. Type of Employment: _____
- c. Present Salary: _____
- d. Are you being compensated for time lost from work? Yes No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? Yes No If yes, please describe, in detail:

23. Other pertinent information: _____

***Life Chiropractic's* TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which caused alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat disease or condition other than vertebral subluxation. Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

NOTE: It is understood and agreed the amount paid to Life Chiropractic for x-ray, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Life Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable, and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read, understand and Hereby request Chiropractic care based on the above agreement.

Date: _____ Signature: _____

Signature of parent or guardian if minor _____