

Lindley Chiropractic Personal Injury Questionnaire

Patient Information

First Name _____ M.I. _____ Last _____
Home Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ E-mail Address _____
Birthdate: ____/____/____ Gender: M F Age: _____
Social Status: Single Married Divorced Widowed Separated
Social Security Number _____
How did you hear about us? Coupon/Gift Cert. Internet Banner Referred By: _____
Employer Name _____ Occupation _____
Employer Address _____

Who to Contact in Case of Emergency:

Name _____ Relation to Patient _____
Home Phone _____ Work phone _____ Ext _____

Insurance information

- Driver of Vehicle in which you were injured: _____
Insurance Company: _____ Policy# _____
Address: _____
- Does their policy include Personal Injury Protection (PIP): Yes No
- Accident Claim #: _____ Insurance Adjuster Name: _____
Adjuster Phone Number: _____
Address to send billing information: _____
- Driver of Other vehicle (if any): _____ Policy# _____
Insurance Company: _____ Address: _____
- Your Insurance Company (if you were in another persons vehicle): _____
Policy #: _____ Does YOUR policy include Personal Injury Protection (PIP): Yes No
- Have you retained an Attorney: Yes No If yes, name of Attorney: _____
Address: _____

Accident Information

- Please explain ***IN DETAIL*** how your accident happened: _____

- Time and Date of Accident: _____
- Where did the accident occur? (Intersection or Highway, etc.) _____

- Were the police notified of the accident? Yes No
- You were heading: North South West East
- Other Vehicle was headed: North South West East
- Were you struck from : Behind Front Drivers Side Passenger Side
- What were the circumstances (were you stopped, moving, turning, etc.)?: _____

- Was any one else in your car at the time of the accident? Yes No Were they injured? Yes No
- You were the: Driver Passenger Front Seat Back Seat Using Seat Belts
- Head rest in proper position (top of head rest at center of back of head)? Yes No

- Did you hit your head or knees: Yes No Seat came loose? Yes No
- What were your immediate symptoms: Dizzy Unconscious, how long: _____
 Pain, where: _____ Other: _____
- Primary Complaint Now: _____
- Pains are: Sharp Dull Throbbing Aching Numbness Shooting
 Burning Tingling Spasm Stiffness Swelling Other _____
- Is this condition getting progressively worse? Yes No Unknown
- Is the pain: Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)
- Does the pain radiate? Yes No, if yes, Where does it radiate? _____
- Activities or movements that are difficult to perform:
 Sitting Standing Walking Bending Lying Down Other _____
- What treatment have you already received for this condition? Medications Physical Therapy
 Surgery Chiropractic None Other _____
- Activities or movements that improve the condition: _____
- Second Complaint _____ When did it start? _____
- Did you go to the Doctor/Hospital after the accident? Yes No If yes, what treatment was given: _____
- Was any other Doctor consulted after your accident? Yes No
If yes, Doctor's name: _____ D.C. M.D. D.O. P.A.
- How many times were you seen? _____ Diagnosis: _____
- Have you had any complaints in involved area before? Yes No
If yes, explain: _____
- Has anyone recommended surgery? Yes No
- How do you feel in a.m.? Better Worse No difference
- How do you feel in p.m.? Better Worse No difference
- Is condition getting worse? Yes No Constant Comes and goes
- Have you been unable to work since the accident? Yes No
Dates unable to work: _____
- Are you partially disabled? Yes No if yes, explain: _____
- What can you **NOT** do now that you could do before?: _____
- Before this injury, were you able to work on an equal basis with others your age? Yes No
- Medications you are taking now due to the Accident: Pain Killers Anti-Inflammatory Muscle Relaxers
Others: _____

Check symptoms you have noticed SINCE THE ACCIDENT:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Nausea, vomiting | <input type="checkbox"/> Face flushed |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Tremors | <input type="checkbox"/> Pallor | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Mental Dullness |
| <input type="checkbox"/> Extreme Nervousness | <input type="checkbox"/> Extreme Fatigue | <input type="checkbox"/> Pain Behind Eyes | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Digestive Disorder |
| <input type="checkbox"/> Equilibrium Disorder | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Upper back- pain, stiff |
| <input type="checkbox"/> Mid-back- pain, stiff | <input type="checkbox"/> Feet cold; Hands cold | <input type="checkbox"/> Restricted Neck Motion | <input type="checkbox"/> Buzzing/Ringing Ears | <input type="checkbox"/> Eyes Sensitive to light |
| <input type="checkbox"/> Head/Shoulders Feel tired/heavy | <input type="checkbox"/> Pins and Needles in arms/legs | <input type="checkbox"/> Numbness in fingers/arms/legs | <input type="checkbox"/> Difficulty in prolonged riding in car | <input type="checkbox"/> Difficulty in excessive lifting |
| <input type="checkbox"/> Neck/Low Back pain/stiffness upon rising | <input type="checkbox"/> Pain radiating into right/left/both arms/leg | <input type="checkbox"/> Difficulty in excessive standing/walking/bending | <input type="checkbox"/> Difficulty in excessive turning/twisting | <input type="checkbox"/> Difficulty in rising to walk after sitting |

Health Information

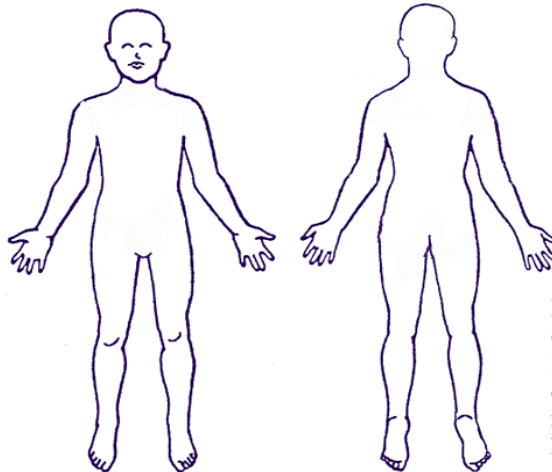
- Date of last Physical Examination: _____ Have you had previous Chiropractic Care?: Yes No
 Doctor's Name: _____ When? _____
 Why? _____ Were x-rays taken? Yes No
- Are you Pregnant? YES NO Nursing? YES NO
- Who is your current medical doctor? _____
- Please list ALL Surgeries you've had: _____
- _____
- Allergies: _____
- Please list ALL Medications you are taking? _____
- _____
- Are you Pregnant? YES NO Nursing? YES NO Taking Birth Control? YES NO
- Do you Smoke? YES NO if Yes, how much? _____ packs/day
- Do you Drink Alcohol? YES NO How Much? _____ glass/ (circle one) Day Week Month Year
- How much do you exercise? _____ minutes/ (circle one) Day Week Month Year

Mark Any Condition you have either had in the Past or Currently Have:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Other _____ |

Pain Diagram

Area of Most Pain		
Better	Pain at Present:	Worse
0-1-2-3-4-5-6-7-8-9-10		
Pain at its Worst:		
0-1-2-3-4-5-6-7-8-9-10		
Pain at its Best:		
0-1-2-3-4-5-6-7-8-9-10		
Area 2 nd Most Pain		
Better	Pain at Present:	Worse
0-1-2-3-4-5-6-7-8-9-10		
Pain at its Worst:		
0-1-2-3-4-5-6-7-8-9-10		
Pain at its Best:		
0-1-2-3-4-5-6-7-8-9-10		



KEY	
Stabbing	xxx
Pins & Needles	ooo
Numbness	==
Aching	+++
Burning	////

Please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort you have been experiencing.

Patient Name _____ Date _____

Financial Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lindley Chiropractic will prepare any necessary reports and forms to assist me in making collection from the third party payer and that any amount authorized to be paid directly to Lindley Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment for services are rendered. A late charge of 1.5% per month (but not to exceed lawful maximum) may be added to any amount sixty (60) days past due if not received prior to the next billing date. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

SIGN HERE _____

Date: _____

Patient Driver's License #: _____

Informed Consent:

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me or the patient for whom I am legally responsible by the doctor of chiropractic who now or in the future treats me. I have had an opportunity to discuss with the doctor of chiropractic and/or with other personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic 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, and I wish to rely on the doctor to exercise judgment during the course of the procedure

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend to consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

SIGN HERE _____

Date _____

(Patient or Legally Authorized Representative)

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided the Lindley Chiropractic Notice of Privacy Practices ("Notice"):

- It tells me how Lindley Chiropractic will use my health information for the purposes of my treatment, payment for my treatment, and Lindley Chiropractic.
- The Notice also explains in more detail how Lindley Chiropractic may use and share my health information for other than treatment, payment, and health care operations.
- Lindley Chiropractic will also use and share my health information as required/permitted by law.

SIGN HERE _____

Date _____

(Patient or Legally Authorized Representative)

Relationship of Legally Authorized Representative to Patient: _____