Personal Injury Questionnaire

Confidential Patient Information

First Name: | Last Name: | Date:
SSN: | DOB: | Gender:
Marital Status: | Spouse's Name: | # of Children:
Address:
Email: | Cell Phone: | Other Phone: | Contact Method: Cell Email
Occupation: | Employer:
Emergency Contact: | Emergency Relation: | Emergency Phone:

Injury/Accident Details

Date of Accident: | Time of Accident: | City: | State:

Please explain in detail how your accident happened:

You were heading: ◯ North ◯ South ◯ East ◯ West on (street or highway)

Other vehicle was heading: ◯ North ◯ South ◯ East ◯ West on (street or highway)

Police were notified? ◯ Yes ◯ No

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

Were you knocked unconscious? ◯ Yes ◯ No – If yes, for how long?

You were struck from: ◯ Behind ◯ Front ◯ Driver Side ◯ Passenger Side

Location in the vehicle: ◯ Driver ◯ Passenger ◯ Front Seat ◯ Back Seat – Using seatbelts? ◯ Yes ◯ No

Check symptoms you have noticed since the accident:

- ☐ Headache
- ☐ Light Sensitive Eyes
- ☐ Head feels heavy
- ☐ Pins and Needles in Arms
- ☐ Sleeping Problems
- ☐ Pins and Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Other:
- ☐ Dizziness
- ☐ Buzzing in Ears
- ☐ Memory Loss
- ☐ Ears Ringing
- ☐ 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

© WELL ALIGNED | WWW.WELLALIGNED.COM

Injury/Accident Details (continued)

What hospital were you taken to (if applicable)? Admitted? ◯ Yes ◯ No
– If yes, how long? Name of doctor:

What was the diagnosis?

What was the treatment? How long were you treated?

Was any other doctor consulted after your accident? ◯ Yes ◯ No
– If yes, what was the doctor's name?

What was the diagnosis?

What was the treatment? How long were you treated?

Have you ever had complaints in the involved area before? ◯ Yes ◯ No
– If yes, please explain:

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: ◯ Improving ◯ Getting Worse ◯ Same

Lifestyle (Not related to the accident)

Are you physically active? ◯ Not at all ◯ Somewhat ◯ For the most part ◯ Yes ◯ Very

Physical activities:

Quality of sleep: ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent

Do you have any emotional or behavioral issues? ◯ Yes ◯ No

Your opinion on chiropractic care? ◯ Skeptical ◯ Curious ◯ Passionate ◯ Indifferent ◯ Nervous ◯ Excited

Symptoms (Not related to the accident)

Check ALL that apply:

☐ Neck Pain	☐ Chronic Sinusitis	☐ Mid Back Pain	☐ Low Back Pain
☐ Headaches	☐ Arm Numbness	☐ Shoulder Pain	☐ Hip Pain
☐ Migraines	☐ Hand Numbness	☐ Heart Disease	☐ Leg Pain
☐ Vertigo	☐ Arm Pain	☐ Asthma	☐ Leg Numbness
☐ Dizziness	☐ Throat Issues	☐ Gastric Reflux	☐ Numbness in Feet
☐ Nausea	☐ Thyroid Problems	☐ Ulcers	☐ Knee Pain
☐ TMJ	☐ Chronic Fatigue	☐ Chest Pain	☐ Kidney Problems
☐ Ear Infections	☐ Fibromyalgia	☐ Chronic Illness	☐ IBS
☐ Anxiety	☐ Lupus	☐ Liver Disease	☐ Bladder Problems

Top 3 Health Concerns	Severity 1=MILD / 10 = UNBEARABLE	Date of Onset	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.				
2.				
3.				

Pain Scale (Not related to the accident)

On a scale of 1 to 10, 10 being worst possible pain...

What is your pain level right now? What is your average level of pain? What is your pain level at its worst?

© WELL ALIGNED | WWW.WELLALIGNED.COM

Health History

List current medications:

List all surgical operations and dates:

Have you ever been in an auto accident? ◯ Yes ◯ No
– If yes, please list dates and injuries:

Have you even had/have: ◯ Stroke ◯ Cancer ◯ Heart Disease ◯ Spinal Surgery ◯ Seizures ◯ Spinal Bone Fracture ◯ Scoliosis ◯ Diabetes ◯ Bone Fracture ◯ Severe Fall ◯ Concussion

Have you ever been under regular chiropractic care? ◯ Yes ◯ No
– If yes, where? Date of last adjustment:

Why are you seeking chiropractic care? ◯ Spinal Correction ◯ Pain Relief ◯ Pain Management ◯ Maintain Health ◯ Sports Performance ◯ Symptom Relief ◯ Quality of Life Improvement

What is your main goal in seeking care at our office?

Family History

Check ALL that apply:

Condition	Spouse	Daughter	Son	Mother	Father	Grandmother	Grandfather
Arthritis	☐	☐	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐	☐	☐
Bed Wetting	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Carpal Tunnel	☐	☐	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Digestive Problems	☐	☐	☐	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐

Patient Signature: ______________________________ Date: ______________

© WELL ALIGNED | WWW.WELLALIGNED.COM

Insurance

Primary Insurance Carrier:		Name of Insured:
Insured DOB:	Member ID:	Group ID:
Secondary Insurance Carrier:		Name of Insured:
Insured DOB:	Member ID:	Group ID:

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits and agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by insurance.

Patient Signature: ______________________ Date: ____________

Disclaimer for PI, Auto, or Workmans Compensation

Dear Patient,
This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank You.

Patient Name: ______________________ DOB: ____________

Patient Signature: ______________________ Date: ____________

Terms of Acceptance

To promote the most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, we state the following to facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding services we provide:

1. Chiropractic is a specific, separate, and distinct practice authorized by law to address spinal health.
2. Chiropractic seeks to restore normal nerve functioning through the adjustment of spinal subluxations to maximize the inherent healing power of the body. Subluxations are deviations from normal spinal structures that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region(s) of the spine with the specific intent of repositioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the united states alone.
4. Chiropractic does not seek to replace or compete with other specific health care professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
5. Your compliance with the doctor’s recommendations is essential to achieving the maximum health benefits.
6. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, what we work to maintain as a supporting, open environment.

By signing below, i am stating that i have fully read and understand the above statements.

Patient Signature: ______________________ Date: ____________

© WELL ALIGNED | WWW.WELLALIGNED.COM