Raab 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

Patient Name_____ **Date**_____

- 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*:

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

Patient Name_____ **Date**_____

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 you 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

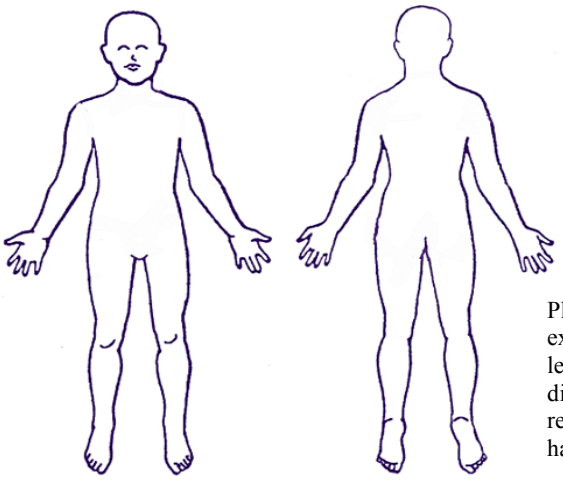
Mark Any Condition you have either had in the Past or Currently Have:

☐AIDS/HIV	☐Depression	☐Liver Disease	☐Psychiatric Care
☐Alcoholism	☐Diabetes	☐Measles	☐Rheumatoid Arthritis
☐Allergy Shots	☐Emphysema	☐Migraine Headaches	☐Rheumatic Fever
☐Anemia	☐Epilepsy	☐Miscarriage	☐Sinus Problems
☐Anorexia	☐Fractures	☐Mononucleosis	☐Stroke
☐Appendicitis	☐Glaucoma	☐Multiple Sclerosis	☐Suicide Attempt
☐Arthritis	☐Goiter	☐Mumps	☐Thyroid Problems
☐Bleeding Disorder	☐Gonorrhea	☐Osteoporosis	☐Tonsillitis
☐Breast Lump	☐Gout	☐Pacemaker	☐Tuberculosis
☐Bronchitis	☐Heart Disease	☐Parkinson's Disease	☐Tumors, Growths
☐Bulimia	☐Hepatitis	☐Pinched Nerve	☐Typhoid Fever
☐Cancer	☐Hernia	☐Pneumonia	☐Ulcers
☐Cataracts	☐Herniated Disc	☐Polio	☐Vaginal Infections
☐Chemical Dependency	☐Herpes	☐Psychiatric Problems	☐Venereal Disease
☐Chicken Pox	☐High Cholesterol	☐Prostate Problems	☐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 Worse: 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 2nd Most Pain
Better Pain at Present: Worse 0—1—2—3—4—5—6—7—8—9—10
Pain at its Worse: 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 Raab Chiropractic will prepare any necessary reports and forms to assist me in making collection from the third party payor and that any amount authorized to be paid directly to Raab Chiropractic & Massage Therapy 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 xrays, on me or the patient for whom I am legally responsible by the doctor of chiropractic who now or in the future treats me while employed at Raab Chiropractic Clinic. 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 Raab Chiropractic Notice of Privacy Practices ("Notice"):

- It tells me how Raab Chiropractic will use my health information for the purposes of my treatment, payment for my treatment, and Raab Chiropractic health care operations.
- The Notice also explains in more detail how Raab Chiropractic may use and share my health information for other than treatment, payment, and health care operations.
- Raab 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:_____