



Lakes Chiropractic



Personal Injury Questionnaire

Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: () ____ - ____ Work Phone: () ____ - ____

Sex: M F Marital Status: S M D W Social Security Number: ____ - ____ - ____

Date of Accident: _____

Where did accident happen? Describe the accident in your own words:

1. What was your position in the car?

Driver: If driver, were your hands on the steering wheel? Left Right Both

Passenger: If passenger, were you sitting in: Front Right Rear Left Rear

2. Did your vehicle strike another vehicle? Yes No

Was your vehicle struck by another vehicle? Yes No

Angles of impact...First Collision: Front Back Left Right

Second Collision: Front Back Left Right

3. Were you wearing a seat belt? Yes No

Did you brace for impact? Yes No ... I braced with my hands feet

Which way were you facing at the time of impact? Straight ahead Left Right

4. Did you strike anything in the vehicle at the time of impact? Yes No

If yes, specify what part of your body struck what. ie...head chest chin shoulder Right/Left knee

Steering wheel _____ Dashboard _____

Windshield _____ Roof _____

Left Side Door _____ Right Side Door _____

Left Side Window _____ Right Side Window _____

Other _____

Did the seat back bend/break? Yes No

5. Immediately following the accident, how did you feel?

Dizzy/dazed disoriented nervous Unconscious nauseous upset weak

other _____

6. Did you go to the hospital? Yes No

Were you admitted? Yes No If yes, how long? _____
If you went to the hospital, when? At time of accident Next day
How did you get to the hospital? Ambulance Police Private transportation

Name of hospital: _____
Attended by Dr. _____

7. What treatment was given?

- None placed in cervical collar x-rayed
- given stitches bandaged given pain medication
- Given instructions regarding concussions Physical therapy
- given instructions regarding sprains/strains
- instructed to call orthopedic surgeon instructed to call a private physician
- Referred to this office for treatment
- other _____

Have you seen any other doctor as a result of this accident Yes No
Doctor's name: _____

Chief complaints or symptoms:

Neck pain: Yes No Left Right
 L shoulder L arm L forearm L hand
R shoulder R arm R forearm R hand

Headache? Yes No
Migraine? Yes No
Middle back pain? Yes No
Ringing in ears? Yes No Left Right Both
Blurry vision? Yes No Left Right Both
Wrist pain? Yes No Left Right Both
Jaw pain? Yes No Left Right Both sides

Low Back pain: Yes No Left Right
Bilateral buttocks
L buttock L thigh L knee L foot
R buttock R thigh R knee R foot

Hip pain? Yes No Left Right Bilateral
Knee pain? Yes No Left Right Bilateral
Foot pain? Yes No Left Right Bilateral

Numbness:

L hand L upper arm R hand R upper arm
L foot L leg R foot R leg

Check any which apply to your condition:

- Dizziness nervousness fatigue anxiety depression excessive irritability
- fear of driving loss of concentration jaw clenching grinding of teeth
- nightmares difficulty sleeping

Additional symptoms/complaints :

Have you lost any time from work due to your injuries? Yes No What dates? _____

Place of employment: _____

Type of employment: _____

Have you had previous injuries or accidents? Yes No

Description of previous accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition?
(Example 100%, 80%, etc.) _____

Draw in your face.

Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Mark areas of radiation. Include all affected areas.

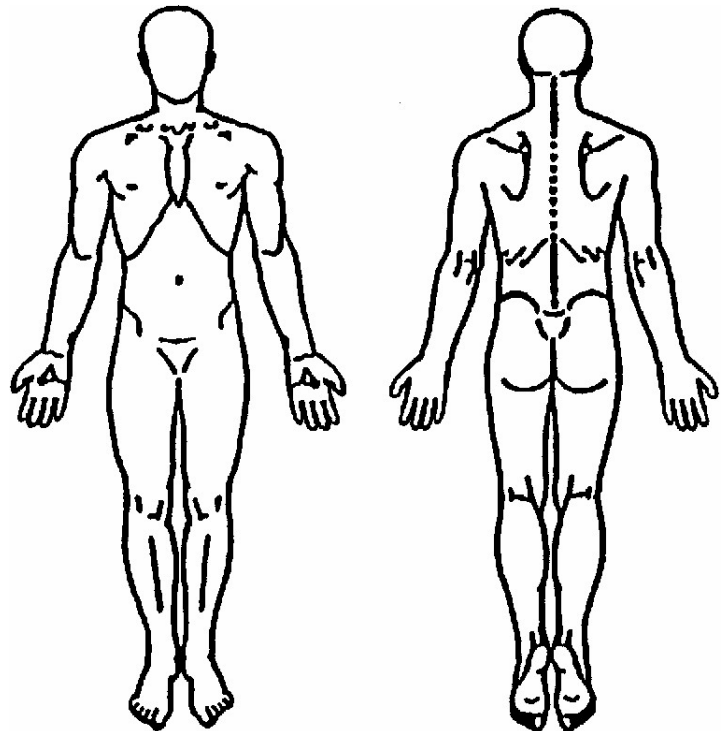
Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

Pins & Needles ○ ○ ○ ○ ○
○ ○ ○ ○ ○
○ ○ ○ ○ ○

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /



I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that Lakes Chiropractic will prepare any necessary reports or forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Lakes Chiropractic will be credited directly to my account upon receipt. However, I clearly understand that I am personally responsible for payment of all charges.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

My signature below certifies I have read and understand these clinic policies.

Patient's signature _____ Date _____

Parent/Guardian signature authorizing care for minor _____ Date _____

In case of emergency, please notify:

Name of nearest relative not living with you _____

Relationship _____ Address _____

Phone number _____

AUTHORIZATION FOR CARE

I hereby authorize Lakes Chiropractic and its doctors to administer care as they deem necessary. I authorize the doctors to take x-rays, perform an exam and administer treatment. I clearly understand and agree that I am personally responsible for payment of any fees not covered by my insurance.

Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic care has only one goal; which is to obtain optimal health. It is

important that each patient understands 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 manual forces to facilitate the body's correcting of vertebral subluxation. Our chiropractic method of correction 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 on the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal exam, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of any findings we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by other. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific manual manipulation of the spine to correct vertebral subluxation.

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. Therefore I accept chiropractic care on this basis.

Signature

Date