Auto Injury Questionnaire

Name: _____DOB: _____Age_____ Height: _____ Weight: _____

Home Phone #: _____ Work Phone #: _____Cell Phone #: _____

Address: _____ E-mail Address: _____

City: _____ State ____Zip: _____How did you hear about our office? _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Employer:_____

ATTORNEY INFORMATION:

Do you have an attorney? ☐ Yes ☐No

Name: _____Phone number: _____

INSURANCE INFORMATION:

Personal Injury Insurance Company Name: _____ Claim #: _____

Adjustor's Name: _____ Adjustor's Phone number: _____

Do you have health insurance as a secondary insurance? ☑ Yes ☐No

Insurance Name: _____ Member Id: _____

Phone #: _____ Policy Holder Name: _____ DOB: _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Effective Chiropractic Inc., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.) I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits, I authorize the use of this signature on all insurance claims,, including electronic submissions.

Patient/Responsible Party Signature: _____ Patient/Responsible Party Print: _____

Date: _____

ACCIDENT INFORMATION:

Date of Injury: _____ Where (State/City):_____Time of Accident: _____am/pm

Please describe the accident in your own words*:*

_____
_____
_____

Were you the: ☐ Driver ☐ Front Seat Passenger (Right) ☐ Back Seat LEFT Passenger ☐ Back Seat RIGHT Passenger

Were others in the car with you? ☐ Yes ☑ No

Make & Model of the car you were in? _____ At-fault vehicle: _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

What was the approximate speed at the time of the impact? Your vehicle _____mph Other vehicle _____ mph

What was the weather like at the time of the collision? ☐ Dry ☐ Wet ☐ Icy

Was your vehicle ☐ Parked ☐ Moving ☐ Stopped with brakes applied

At the time of the impact were you: ☐Looking straight ahead ☐ Looking to the left ☐Looking to the right ☐Looking down ☐ Looking up

Were you braced for the impact (did you see it happening and braced for it)? ☐Yes ☐No

Were you wearing a seat belt? ☐ Yes ☐ No Did the seat belt break as a result of the impact? ☐ Yes ☐ No

Did the seat belt have a shoulder harness? ☐ Yes ☐ No If yes, did it contribute to the pain you are experiencing? ☐ Yes ☐No

Do you have any bruises from the seatbelt? ☐ Yes ☐ No Did the air bag deploy? ☐ Yes ☐ No

Did your seat have a head restraint (headrest)? ☐ Yes ☐ No Did your head ride over the headrest? ☐ Yes ☐ No

Did you hit anything inside the vehicle? ☐ Yes ☐ No

Check all that apply: ☐ Seatbelt Restraint ☐ Steering Wheel ☐Dashboard ☐ windshield ☐ side door ☐ side window ☐Other_____

Which part of your body? ☐Chest ☐Head ☐Chin ☐Face ☐R and/or L Knee ☐R and/or L shoulder ☐R and/or L Hand ☐Other_____

Did your vehicle strike the other vehicle or object? ☐ Yes ☐ No If yes, explain: _____

How much damage was there to the outside of the vehicle? ☐None/ Scratch ☐Moderate ☐A lot ☐ Totaled

Estimated damage amount: $_____

Did you experience immediate pain? ☐ Yes ☐ No If yes, Where: _____

Immediately after the accident were you: ☐ Conscious ☐ Dazed ☐ Unconscious

Were the police called to the scene? ☐ Yes ☐ No If no, why not? _____

Were any tickets issued and to whom? ☐ Yes ☐No if yes: _____

Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No If no, why not? _____

Were you taken to the hospital? ☐ Yes ☐ No Did you drive to the hospital? ☐ Yes ☐ No

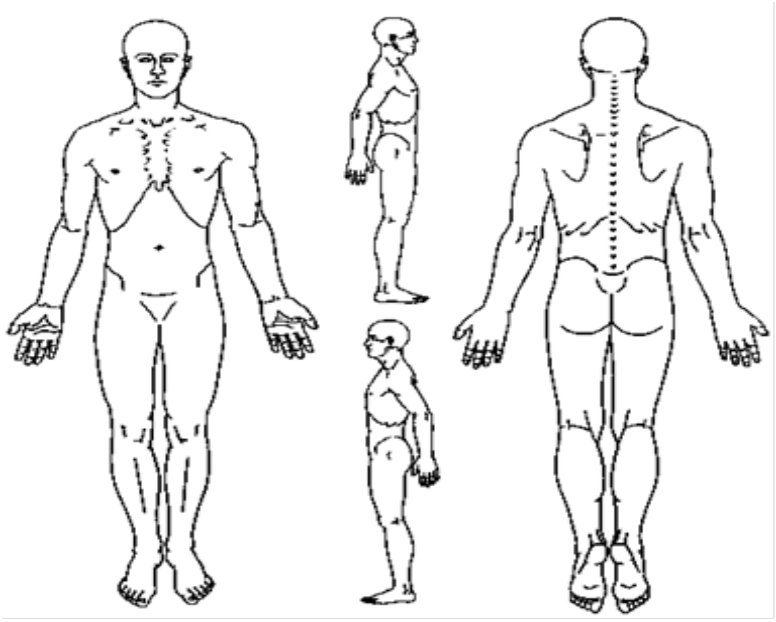
Which hospital? _____When? _____

Were x-rays taken? ☐ Yes ☐ No **MRI?** ☐ Yes ☐ No **CT**? ☐Yes ☐No

Did they prescribe medication? ☐ Yes ☐ No if yes, what medication? _____

Have you seen any other medical providers for injuries related to this accident? ☐ Yes ☐No
If yes, list all providers, their specialty, and treatment dates:
_____

CHECK AREAS OF PAIN OR DISCOMFORT FOR ALL COMPLAINT(S):



RATE LEVEL OF DISCOMFORT ON A SCALE OF 1-10 (10 IS THE WORST PAIN)

NECK PAIN: ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

SHOULDER/ARM PAIN: ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

MID BACK PAIN: ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

LOW BACK PAIN: ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

HIP/LEG PAIN (RIGHT OR LEFT): ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

HEADACHE PAIN: ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

OTHER PAIN: _____ ☐ **None** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Severe**
Percentage of time you feel the discomfort: ☐ 100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐ 10%
What does the pain feel like? ☐ Achy ☐ Burning ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Tingling
Does the pain radiate? ☐ Yes ☐ No. If yes, explain: _____
When did the pain start? _____
Did you have this pain before the accident? ☐ Yes ☐ No Explain:_____

What makes the pain worse?
☐ Bending ☐ Cleaning ☐ Cooking ☐ coughing ☐ dressing ☐ driving ☐ exercising ☐ kneeling ☐ lifting ☐ lying ☐ reaching ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ standing ☐ sneezing ☐ turning ☐ typing ☐ walking ☐ working Other _____

What makes the pain better? ☐ Resting ☐ Sitting ☐ Stretching ☐ Therapy ☐ Pain medication ☐ Nothing other: _____

My pain is ☐ Constant ☐ Intermittent ☐ Worse in AM ☐ Worse in PM

How does the pain affect your life? ☐ Lose patience with spouse/children ☐ Restricted household duties ☐ Hinders ability to exercise ☐ Restricted in your daily activities ☐ Interferes with work ☐ Interrupts sleep

What type of work do you do? _____ List job requirements: _____

Have you lost any days of work from this injury? ☐ Yes ☐ No **If yes, give dates:_____**

SYMPTOMS: Please check if you have experienced any of the following since this accident.

☐ Tired/Fatigued	☐ Difficulty talking	☐ Difficulty Sleeping
☐ Ringing in Ears	☐ Dizziness	☐ Vomiting
☐ Unclear Thinking	☐ Nausea	☐ Changes in Vision
☐ Difficulty swallowing	☐ Difficulty with balance	☐ Other: _____

PREVIOUS ACCIDENT HISTORY*:*
Have you been involved in other vehicle accidents? ☐ Yes ☐ No Please describe and give dates:_____
When was your last treatment for injuries related to that accident? _____

FAMILY HISTORY:
Is there a family history of any of the following conditions?
Heart Disease _____ Diabetes _____Cancer: _____ Arthritis: _____

MEDICAL HISTORY:
Please check if you have currently or have any of the following conditions:

- ☐ NONE
- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ ALCOHOLISM
- ☐ ALLERGY SHOTS
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ APPENDICITIS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLEEDING DISORDER
- ☐ BLOOD PRESSUE (HIGH OR LOW-
- ☐ CIRCLE) *ALTA o BAJA*
- ☐ BREAST LUMP
- ☐ BROKEN BONES
- ☐ BRONCHITIS
- ☐ BULIMIA
- ☐ CANCER
- ☐ CATARACTS
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ COLON TROUBLE
- ☐ DIABETES
- ☐ EAR INFECTIONS
- ☐ EPILEPSY
- ☐ GALL BLADDER PROBLEMS
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART ATTACK
- ☐ HEART PROBLEMS
- ☐ HEMORRHOIDS
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HERNIATED DISC
- ☐ HERPES
- ☐ HIGH CHOLESTEROL
- ☐ HORMONE PROBLEMS
- ☐ INSOMNIA
- ☐ KIDNEY PROBLEMS
- ☐ LIVER DISEASE
- ☐ MEASLES
- ☐ MENOPAUSAL PROBLEMS
- ☐ MIGRAINES
- ☐ MISCARRIAGE
- ☐ MULTIPLE SCLEROSIS
- ☐ MUMPS
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER
- ☐ PARKINSON'S DISEASE
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTATE PROBLEMS
- ☐ PROSTHESIS
- ☐ PSYCHIATRIC CARE
- ☐ RHEUMATOID ARTHRITIS
- ☐ SEXUAL DIFFICULTY
- ☐ STROKE
- ☐ SUICIDE ATTEMPT
- ☐ THYROID PROBLEMS
- ☐ TMJ PAIN
- ☐ TONSILLITIS
- ☐ TREMORS
- ☐ TUBERCULOSIS
- ☐ TUMORS/GROWTHS
- ☐ TYPHOID FEVER
- ☐ ULCERS
- ☐ VENERAL DISEASE
- ☐ OTHER_____

Social History:
What is your daily/weekly intake of the following:

Caffeine _____cups/day Alcohol _____drinks/week Cigarettes _____pack(s)day

Exercise:
☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Allergies:
Check any known allergy you have:

- ☐ **NONE**
- ☐ MILK
- ☐ EGGS
- ☐ PEANUTS
- ☐ ALMONDS
- ☐ CASHEW
- ☐ WALNUTS
- ☐ FISH
- ☐ SHELLFISH
- ☐ SOY
- ☐ WHEAT
- ☐ GLUTEN
- ☐ PENICILLIN
- ☐ SULFA DRUGS
- ☐ TETRACYCLINE
- ☐ CODEINE
- ☐ NSAIDS
- ☐ PHENYTOIN
- ☐ CARBAMAZEPINE
- ☐ MOLD
- ☐ DUST
- ☐ FUNGUS
- ☐ MITES
- ☐ TREE POLLEN
- ☐ WEED POLLEN
- ☐ DOG DANDER
- ☐ CAT DANDER
- ☐ LATEX
- ☐ OTHER: _____

Are you currently under medical care for any condition? ☑ Yes ☐ No
Explain: _____

Please list any and all medications you are currently taking:

_____
_____

Please list any surgeries and/or hospitalization you have had (type & date):

_____
_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):

_____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health, I will give complete and accurate information during my exam.

Print Name: _____

Signature: _____ Date: _____

X-ray Questionnaire: FOR WOMEN ONLY –

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I may be pregnant at this time

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because

_____

Date of last menstrual period: _____

Patient Signature: _____ Date: _____