PERSONAL INJURY/
WORKMEN'S COMPENSATION QUESTIONNAIRE

NAME________________________ Date of Accident ________________ Time__________

Where did the accident happen?____

Describe the accident in your own words ____

____

____

What was your position in the car? ❑ Driver ❑ Passenger If passenger, were you sitting in ❑ Front ❑ Right Rear ❑ Left Rear

Did your vehicle strike other vehicle? ❑ Yes ❑ No Was your car struck by other vehicles? ❑ Yes ❑ No

Was the impact from the front? ❑ From the left side? ❑ From the rear?

At the time of impact, were you ❑ looking straight ahead? ❑ Looking right? ❑ Looking left?

Were both hands on the steering wheel? ❑ Yes ❑ No Was your foot on the brake? ❑ Yes ❑ No Were you braced for impact? ❑ Yes ❑ No

Where in the car were you after the accident?____

Were you wearing seat belts? ❑ Yes ❑ No Did you strike anything in the vehicle at time of impact? ❑ Yes ❑ No

If yes, specify: ❑ Steering Wheel ❑ Dashboard ❑ Windshield ❑ Side Door ❑ Arm Rests Side ❑ Window ❑ Other __________

Please state part of body: ❑ Chest ❑ Knee ❑ Shoulder ❑ Hand ❑ Head ❑ Other__________________

Immediately following the accident, how did you feel? ____

____

Were you unconscious? ❑ Yes ❑ No In a daze? ❑ Yes ❑ No Did you go to the hospital? ❑ Yes ❑ No

If you went to the hospital, when? At the time of accident ❑ Yes ❑ No Next day ❑ Yes ❑ No

How did you get to the hospital? Ambulance ❑ Yes ❑ No Private transportation ❑ Yes ❑ No

Did the ambulance attendants place you in: Neck Collar ❑ Yes ❑ No Splints ❑ Yes ❑ No Brace ❑ Yes ❑ No

Name of hospital ____

Attended by Doctor ______________________________ Were you x-rayed at hospital? ❑ Yes ❑ No

If so, what was the diagnosis?____

Were you admitted to the hospital? ❑ Yes ❑ No How long did you stay? ______________________

What treatment was rendered?____

What recommendations were made? See own doctor ❑ Yes ❑ No See orthopedic doctor ❑ Yes ❑ No Physical Therapy ❑ Yes ❑ No

Have you seen any other doctors as a result of this accident? ❑ Yes ❑ No

Doctor's Name____

Is your pain consistent? ❑ Yes ❑ No Is the pain on and off? ❑ Yes ❑ No Sharp? ❑ Yes ❑ No Dull? ❑ Yes ❑ No

Other ____

Is your pain worse when arising from a chair? ❑ Yes ❑ No Is it made worse by straining? ❑ Yes ❑ No By coughing? ❑ Yes ❑ No

By sneezing? ❑ Yes ❑ No By straining when moving your bowels? ❑ Yes ❑ No

Do you have any numbness of tingling in the arms? ❑ Yes ❑ No In your hands? ❑ Yes ❑ No In your fingers? ❑ Yes ❑ No

In your legs? ❑ Yes ❑ No In your feet? ❑ Yes ❑ No In your toes? ❑ Yes ❑ No

What is your most comfortable position? Sitting ❑ Yes ❑ No Lying on your right side ❑ Yes ❑ No On your left side ❑ Yes ❑ No

Lying on your back ❑ Yes ❑ No On your stomach ❑ Yes ❑ No Standing ❑ Yes ❑ No

Other ______________________________ Is it difficult for you to move around in bed? ❑ Yes ❑ No

Does stretching and twisting worsen the pain? ❑ Yes ❑ No

Do any of the following relieve your pain? ❑ Heating Pad ❑ Hot Bath ❑ Shower ❑ Ice Pack

Does a brace (if you have tried one) relieve the pain? ❑ Yes ❑ No

Does a change in heel height worsen the pain? ❑ Yes ❑ No Do you feel better moving around? ❑ Yes ❑ No Or resting? ❑ Yes ❑ No

Do you have a firm mattress? ❑ Yes ❑ No Do your knees ache or hurt? ❑ Yes ❑ No Do you have cramps in the leg? ❑ Yes ❑ No

Do you have cramps in your arm? ❑ Yes ❑ No Have you had any change in your bowel habits? ❑ Yes ❑ No

Have you lost any time from work because of this accident? ❑ Yes ❑ No

If yes, give dates of time lost. From____________________ to ____________________

Totally disabled from__________ to__________ Partially disabled from____________________ to __________

SCORE YOUR ACCIDENT. Estimate your total lifting effort ability:

How much weight? ❑ Maximum ❑ Average

How far could you carry this weight?____________ For how long a period of time? ____________

Was this lifting done at work? ❑ Yes ❑ No Or at home or elsewhere? ❑ Yes ❑ No

How often did you carry this amount of weight? ____________

AFTER YOUR ACCIDENT. Describe your total lifting ability:

How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? ____________

Did you experience this pain, discomfort, or restriction of motion before your accident? ❑ Yes ❑ No

How far can you carry this weight?____________ And for how long a period of time? ____________

How often can you carry this weight? ____________

Are you now limited in your lifting ability in some body position that you were previously not? ❑ Yes ❑ No

If so, specify position ____________

What symptoms does lifting produce: ____________

How long do these symptoms last? ____________

Are you presently able to:

WORK ❑ Very heavy______ lbs. ❑ Heavy______ lbs. ❑ Light______ lbs. ❑ Sitting______ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort? ❑ Standing ❑ Walking ❑Sitting

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

❑ Standing______ ❑ Walking______ ❑ Sitting______

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity? ❑ Yes ❑ No

Do you feel that you cannot perform any physical work activity? ❑ Yes ❑ No

Do you feel you cannot perform any mental work? ❑ Yes ❑ No

Rate your BEFORE injury capacity (mark "B") and your AFTER injury capacity (mark "A") for performing activities:

Activity	Normal	Limited	Difficult	Pain
1. Walking				
2. Standing				
3. Sitting				
4. Bending				
5. Stooping				
6. Lifting				
7. Pushing				
8. Pulling				
9. Climbing				
10. Reaching				
11. Gripping				
12. Kneeling				
13. Balance				
14. Fatigue				

Generally speaking, is your inability to perform these functions due to ❑ Pain ❑ Weakness ❑ Structural limitations ❑ Nerves

Do you have normal sexual functions? ❑ Yes ❑ No

Are you able to take care of your personal self, such as dressing, bathing, etc? ❑ Yes ❑ No Or do you require assistance? ❑ Yes ❑ No

Do you feel your present condition is temporary? ❑ Yes ❑ No Or permanent? ❑ Yes ❑ No

Patient's Signature ____________ Date____________

chiropractic

remove obstacles • restore function • improve performance • maximize potential

Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT INFORMATION

last name	first name	m.i.

age	date of birth	social security #	sex ☐ male ☐ female

Are you here because you were involved in a vehicle collision? ☐ yes ☐ no

Are you here because you were injured at your place of employment? ☐ yes ☐ no

Are you here because you were involved in another type of accident? ☐ yes ☐ no

Who is responsible for this account?

Will you be using health insurance to supplement payment to our office*? ☐ yes ☐ no

* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

2 INSURANCE COVERAGE

type of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Workers' Compensation ☐ TRICARE/CHAMPUS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins ID#	primary ins group#
secondary insurance company	secondary ins ID#	secondary ins group#

3 INSURED INFORMATION

Are the insured and patient the same person? ☐ yes ☐ no If YES, do not complete section 3.

last name	first name	m.i.

street

city	state	zip

age	date of birth	social security #	sex ☐ male ☐ female

relationship to insured ☐ spouse ☐ dependent ☐ Other ____________________

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you - supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

____
patient or guardian signature

____
date

1 BENEFITS ASSIGNMENT

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

patient or guardian signature ______________________ date ______________________

2 INFORMATION RELEASE

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

patient or guardian signature ______________________ date ______________________

INSURANCE VERIFICATION

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a **Workers' Comp** case?	☐ yes	☐ no
Has the injury been reported?	☐ yes	☐ no
Name:		
Title:		
Is patient currently employed at place of injury?	☐ yes	☐ no
Name of person authorizing care:		

Is this an **Auto Collision** or **Personal Injury** case?	☐ yes	☐ no
Has it been reported to the insurance company?	☐ yes	☐ no
Has an application for benefits been filed?	☐ yes	☐ no
Did the police write a report?	☐ yes	☐ no
Is auto or PI insurance primary?	☐ yes	☐ no
Agent name and contact info:		

Does the plan cover the following services?		
chiropractic adjustments	☐ yes	☐ no
modalities:		
hot/cold packs	☐ yes	☐ no
mechanical traction	☐ yes	☐ no
electric stimulation	☐ yes	☐ no
ultrasound	☐ yes	☐ no
therapeutic exercise and activities	☐ yes	☐ no
neuromuscular re-education	☐ yes	☐ no
massage	☐ yes	☐ no
manual therapy technique	☐ yes	☐ no
exams	☐ yes	☐ no
supports, braces, collars	☐ yes	☐ no
pillows	☐ yes	☐ no
nutritional supplements	☐ yes	☐ no
orthotics	☐ yes	☐ no
other: ______________________	☐ yes	☐ no
other: ______________________	☐ yes	☐ no

Does the plan have a deductible?	☐ yes	☐ no
Amount for an individual:		
Amount for the family:		
Amount currently met:		
When does the deductible renew?		
Do charges for diagnostic tests apply to the deductible?		
What is the co-pay after the deductible is met?		
What is the maximum yearly benefit?		
What is the yearly visit cap?		
Does the company assign benefits to the doctor?	☐ yes	☐ no
Are any special forms required to file claims?	☐ yes	☐ no
What is the name of the person that you spoke with?		
Last:		
First:		
ID#	Extension:	
Notes:		

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