

Personal Injury Form

Patient Information

Today's Date _____ Date of Injury _____

First Name _____ Phone 1 _____ Marital Status _____
Last Name _____ mobile home work single married other

DOB _____ Phone 2 _____ Working Status _____
Sex male female mobile home work employed
SSN _____ Email _____ full-time student
Address _____ Employer _____ part-time student
City _____ Employer Phone _____
State _____ Occupation _____
Zip Code _____

Insurance

Primary Insurance

Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____

Relationship to Insured self spouse child other

Secondary Insurance

Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____

Relationship to Insured self spouse child other

Accident History

When did the accident occur? _____ days ago _____ weeks ago _____ years ago other _____

What time of day did the accident occur? morning afternoon evening night

Where did the accident occur? at a commercial location at a medical facility at work at home
 during sports during recreation other _____

The injury was a result of? a fall a dental accident a holiday accident a medical accident assault
 automobile accident bending being hit industrial disease (asbestosis, mesothelioma, etc.)
 occupational stress/repetitive strain product defect sitting tripping other _____

What areas of your body experienced injury? back (upper) back (middle) back (lower) head face jaw
 neck shoulder (left) shoulder (right) chest arm (left) arm (right) elbow (left) elbow (right)
 hand (left) hand (right) fingers (left hand) fingers (right hand) hip (left) hip (right) leg (left) leg (right)

knee (left) knee (right) shin (left) shin (right) foot (left) foot (right) toes (left foot) toes (right foot)

Did you lose consciousness? yes no

If work related, name, address and details of your employer

Did anyone witness the accident? no one person two people three people several people

If yes, name, address and details of the witness or witnesses

Who did you report the accident to? no one attorney insurance company employer family member(s)

friend(s) police officer

Name, address and details of who you reported the accident to

Did you retain an attorney? yes no Attorney Name _____

If yes, provide attorney information Attorney Address _____

Attorney Phone _____

How often have you been receiving treatment? daily twice per week four times per week

five times per week weekly bi-weekly monthly

From whom have you been receiving treatment?

How many days of work have you missed as a result of this accident? _____

Did you go to hospital? yes no

Hospital Information

Hospital Name _____ Hospital Location _____

Were you hospitalized overnight? yes no

Were you prescribed anything? arm brace crutches knee brace leg brace muscle relaxers

neck brace pain medication topical analgesic wrist brace other _____

What services were performed at the hospital? none evaluation by a medical doctor x-rays MRI CT scan

cast emergency life saving procedures blood transfusion stitches other _____

What types of diagnostic tests have been performed? amniocentesis basic metabolic panel biopsy CAT scan

celiac profile colonoscopy complete blood count complete blood count with differential

comprehensive metabolic panel diagnostic ultrasound echocardiogram electrolyte panel endoscopy

extended cardiac risk profile hepatic function panel hepatitis panel, acute hepatitis panel, chronic

lipid panel mammogram MRI OB profile PET scan renal panel urinalysis X-ray or X-ray series

Condition

What treatments have you received since the accident? ice heat oral pain medication topical analgesics
 muscle relaxers wrist brace knee brace neck brace ankle brace crutches other _____

How often have you been receiving treatment? daily twice per week three times per week
 four times per week five times per week weekly bi-weekly monthly

Details of treatment received

Location and provider where previous treatment was received

Are you responding to treatment? the same improving worse other _____

How did you feel immediately following the accident? head pain neck pain neck stiffness
 jaw/facial pain (TMJ) shoulder pain shoulder stiffness arm pain chest pain back pain low back pain
 lower limb pain back stiffness ear buzzing/ringing in the ears feet/toe numbness or tingling
 hands/fingers numbness or tingling upper limb numbness or tingling cold feet cold hands cold sweats
 constipation anxiety depression diarrhea difficulty swallowing dizzy/dazed disoriented
 fainting fatigue forgetfulness impaired concentration irritability sensitivity to light
 sensitivity to noise loss of balance loss of smell loss of taste loss of memory muscle spasms
 nauseous nervousness pins and needles restlessness shortness of breath sleeping problems
 stomach upset tension vision blurred weakness

What symptoms have you experienced since the accident? head pain neck pain neck stiffness
 jaw/facial pain (TMJ) shoulder pain shoulder stiffness arm pain chest pain back pain low back pain
 lower limb pain back stiffness ear buzzing/ringing in the ears feet/toe numbness or tingling
 hands/fingers numbness or tingling upper limb numbness or tingling cold feet cold hands cold sweats
 constipation anxiety depression diarrhea difficulty swallowing dizzy/dazed disoriented
 fainting fatigue forgetfulness impaired concentration irritability sensitivity to light
 sensitivity to noise loss of balance loss of smell loss of taste loss of memory muscle spasms
 nauseous nervousness pins and needles restlessness shortness of breath sleeping problems
 stomach upset tension vision blurred weakness

Describe the pain? aching burning cramping deep dull numb radiating
 sharp shooting stabbing stiff swelling tight tingling throbbing

Does the pain travel anywhere else? denies radiating pain TMJ left TMJ right TMJ cranium (headache)
 left cranium (headache) right cranium (headache) cervical left upper cervical right upper cervical
 left lower cervical right lower cervical upper thoracic left upper thoracic right upper thoracic
 mid thoracic left mid thoracic right mid thoracic lower thoracic left lower thoracic right lower thoracic
 anterior rib left anterior rib right anterior rib posterior rib left posterior rib right posterior rib
 upper lumbar left upper lumbar right upper lumbar lower lumbar left lower lumbar right lower lumbar
 lumbosacral right lumbosacral left lumbosacral right sacroiliac left sacroiliac left anterior shoulder

- right anterior shoulder left posterior shoulder right posterior shoulder right arm left arm right elbow
 left elbow right forearm left forearm right wrist left wrist right hand left hand right hip
 left hip right leg left leg right thigh left thigh right knee left knee right calf
 left calf right ankle left ankle right foot left foot

Rate your pain on a scale of 0 to 10. *0 being no pain at all and 10 being the worst pain imagineable*

- 0 1 2 3 4 5 6 7 8 9 10

Did you receive X-rays for this injury? yes no

If yes, by whom?

- If yes, which areas were X-rayed?** skull (head) cervical (neck) thoracic (mid back) ribs lumbar (low back)
- sacral/pelvis chest abdomen left shoulder right shoulder left elbow right elbow
 left wrist right wrist left hand right hand left hip right hip left upper leg right upper leg
 left knee right knee left lower leg right lower leg left ankle right ankle left foot right foot

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____
 And assign directly to the above named Chiropractic clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named Chiropractic clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

 Signature of Patient, Parent, Guardian or Personal Representative Date _____

 Print Name of Patient, Parent, Guardian or Personal Representative Date _____