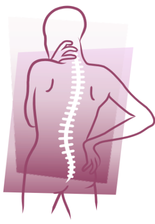

# Chugach Chiropractic Clinic LLC

## *Personal Injury Questionnaire*

Name:______________________________________________ Date:____________________

1. Date of Accident:__________________________________ Time:______________ a.m./p.m.
2. Describe what happened?______________________________________________________
_______________________________________________________________________
_______________________________________________________________________
3. Describe how you felt immediately after the accident?______________________________
_______________________________________________________________________

   How did you feel later that day/night?__________________________________________
_______________________________________________________________________

   How did you feel the next day(s)?______________________________________________
_______________________________________________________________________

4. Check symptoms apparent since the accident:

- ☐ headache
- ☐ neck pain/stiffness
- ☐ mid-back pain
- ☐ low-back pain
- ☐ eyes sensitive to light
- ☐ pain behind eyes
- ☐ dizziness
- ☐ fainting
- ☐ ringing/buzzing in ears
- ☐ loss of balance
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of memory
- ☐ fatigue
- ☐ tension
- ☐ shortness of breath
- ☐ irritability
- ☐ depression
- ☐ sleeping problems
- ☐ numbness in toes
- ☐ numbness in fingers
- ☐ cold hands
- ☐ cold feet
- ☐ diarrhea
- ☐ constipation
- ☐ chest pain
- ☐ nervousness
- ☐ cold sweats
- ☐ anxious
- ☐ other:________________________

5. What is your occupation?________________________ Employer?______________________
6. Have you missed time from work/school? ☐ yes ☐ no

   If you have missed time from work, how much time have you missed?__________________
_______________________________________________________________________

7. Did you seek medical help immediately/soon after the accident? ☐ yes ☐ no

   If yes, how did you get there?________________________________________________
8. Doctor/hospital/clinic seen:_________________________________ Date:______________
9. What was done?_________________________________________________________

   Were x-rays taken? ☐ yes ☐ no If yes, of what body part?_____________________________
10. What treatments/prescriptions were given? ☐ bed rest ☐ brace ☐ adjustments ☐ medications
_______________________________________________________________________
11. What benefit(s) did you receive from treatment(s)?_______________________________
_______________________________________________________________________
12. Date of last treatment:_____________________________________________________
13. Are any of your activities of daily living any different now compared to before the accident? ☐ yes ☐ no

    List anything you are unable to do:_____________________________________________

    List anything that is painful to do:_____________________________________________

    List anything that is difficult to do:____________________________________________

## ***Insurance Information***

Patient's personal insurance:
Insured's name (if other than patient)________________________________________Policy #:____________________________
Insurance Company Name:________________________________________________Phone#:____________________________
Address:__________________________________________ City:_________________________ State/Zip:___________________
Claim #:___________________________________________ Adjuster's name/phone:____________________________________

Other party's insurance:
Insured's name (if other than patient)________________________________________Policy #:____________________________
Insurance Company Name:________________________________________________Phone#:____________________________
Address:__________________________________________ City:_________________________ State/Zip:___________________
Claim #:___________________________________________ Adjuster's name/phone:____________________________________

Other insurance:
Insured's name (if other than patient)________________________________________Policy #:____________________________
Insurance Company Name:________________________________________________Phone#:____________________________
Address:__________________________________________ City:_________________________ State/Zip:___________________
Claim #:___________________________________________ Adjuster's name/phone:____________________________________

## ***Patient's Demographic Information***

Patient's full name:_______________________________________________ Social Security #:___________________________

Address:_________________________________________________________ Date of Birth:_______________________________

Mailing address (if different):________________________________________Phone:____________________________________

Employer name:___________________________________________________ Occupation:________________________________

Employer's address:_______________________________________________ Work phone:________________________________

Spouse's name:___________________________________________________ Spouse's Social Security #:__________________

Spouse's employer:________________________________________________ Occupation:________________________________

## ***Assignment of Payment***

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Chugach Chiropractic Clinic LLC any monies due on account, the same to be deducted from any settlement made on my behalf.

Further, I agree to pay Chugach Chiropractic Clinic LLC the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Chugach Chiropractic Clinic LLC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature:________________________________________________________ Date:______________________________

Printed name:_________________________________________________________________________________________________

Witness:______________________________________________________________________________________________________