Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name ______________ Sex ______ Marital Status ______ Date of Birth ______ Home Phone ______

Address ______________ City ______________ State ______ Zip ______

Occupation ______________ Who referred you to our office? ______________
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # ______ Business Phone ______ Company Name ______________ Location ______

Spouse's First Name ______ Spouse's Soc. Sec. # ______ Spouse's Employer ______________ Location ______

Please explain in detail how your accident happened ______________

Insurance Co. ______________ Policy No. ______ Claim No. ______

Driver of other vehicle (if any)

Name ______________ Insurance Company ______ Policy No. ______

Driver of vehicle in which you were injured (if applicable)

Name ______________ Insurance Company ______ Policy No. ______

Name of your insurance adjustor ______________

Have you retained an attorney? ☐ Yes ☐ No

If so, his name and address ______________

You were heading ☐ North ☐ East ☐ South ☐ West on ______________ (street or highway)

Other vehicle was headed ☐ North ☐ East ☐ South ☐ West on ______________ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? ______________

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

What were the time and date of present injury? ______________

Where did you feel pain immediately after the accident? ______________

Where were you taken after the accident? ______________

What treatment was given? ______________

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? ______________ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

What was the diagnosis? ______________

What treatment was given? ______________

How often did you see the doctor? ______________

How long did you see the doctor? ______________

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? ______________

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving? ☐ Getting worse? ☐ Same?

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1—never had; 2—previously had; 3—presently have.

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

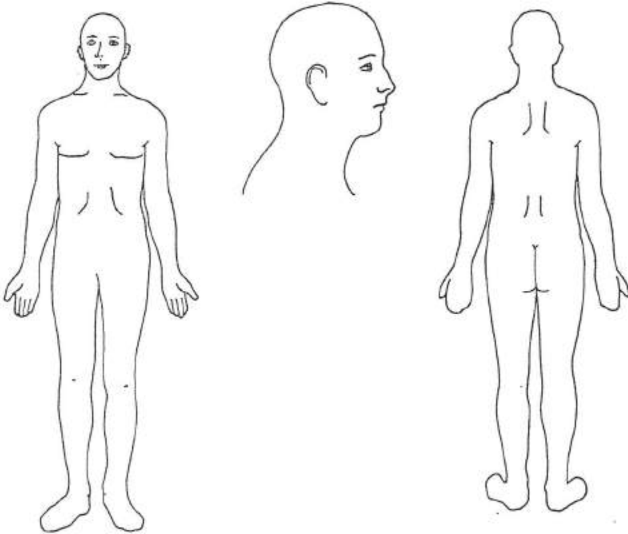
FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?

_____ Yes _____ No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

____
Patient's Signature

.... DO NOT WRITE BELOW THIS LINE ....

Patient accepted? Yes_____ No_____ Doctor's signature_______________________________

Chiropractic Care and Rehab Center, LLC
Estero Park Commons
9250 Corkscrew Road, Suite 4
239.495.1166 t
239.495.0116 f

Christopher M. Green, DC
Michelle M. Giroux, DC

DOCTOR'S LIEN

Patient: ______________________________

Date of Incident: ______________________________

I do hereby authorize **Chiropractic Care and Rehab Center, LLC** to furnish to you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for professional services rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and compensate said doctor. And I hereby further give a LIEN on my case to said doctor against any and all proceeds, judgment or verdict which may be paid to you my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him/her for service rendered me and that this said agreement is made solely for said doctor's additional protection and in consideration if his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee not to exceed over $400.00.

I agree to notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such submitted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

______________________________ ______________________________

Patient's Signature date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

______________________________ ______________________________

Attorney's Signature date

Please date, sign and return one copy to doctor's office. Also keep on copy for your records.

Doctor: Christopher M. Green, DC and Michelle M. Giroux, DC
Address: 9250 Corkscrew Road, Ste 4, Estero, FL 33928

9250 Corkscrew Rd., Suite 4
Estero, FL 33928
Phone: (239) 495-1166
Fax: (239) 495-0116

Authorization To Disclose Health Information

Patient Name______________________ ______________________ ______________
Last First Middle Initial

Home Phone______________ Work Phone______________ Birth date__________

The undersigned hereby authorizes and requests :

____
Name of Health Care Facility or Privider

City______________ State______ Fax__________ Phone__________

Check the box next to each type of information to be disclosed (include dates where indicated):

- ☐ Most recent history and physical or specific date(s)__________
- ☐ Most recent discharge summary or specific date(s)__________
- ☐ Consultation reports, specify date(s)__________
- ☐ Laboratory results, specify types or dates__________
- ☐ Other diagnostic testing results, specify types or dates__________
- ☐ Entire record, specify date__________
- ☐ Abstract, specify date (includes only pertinent treatment information)__________
- ☐ Other, specify__________
- ☐ Including HIV/AIDS testing, results, and/or treatment records
- ☐ Including Mental Health treatment records, excluding psychotherapy notes
- ☐ Including alcohol and/or drug abuse treatment records

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Chiropractic Care & Rehab Center or mail to the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of health information, I can contact Chiropractic Care & Rehab Center at (239) 495-1166.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

____

If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

______________________ ______________________
Signature of Patient or Legal Representative If signed by Legal Representative, Relationship to Patient

____
Date

Rev. 08/08/14