PERSONAL INJURY QUESTIONNAIRE

Name_____ Phone ( )_____

Address_____ City_____ State_____ Zip_____

Age_____ Birth Date_____ Sex_____ S.S.N._____

Employer_____ Address_____

Did you report this to **YOUR** Car Insurance? Yes No (Circle One)

Your Car Insurance Co. is_____ Claim #_____

Claims Adjuster for this Claim_____ Phone #_____

Name on Policy (if other than yourself)_____

ATTORNEY INFORMATION

Name_____ Phone ( )_____

Address_____ City_____ State_____ Zip_____

Were there Witnesses? ( ) Yes ( ) No Name(s)_____

NATURE OF ACCIDENT

1. Date of accident_____ Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle_____
4. Were you wearing your seat belt? ( ) Yes ( ) No
5. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
6. What direction was other vehicle headed? ( ) North ( ) South ( ) Left Side ( ) Right Side
7. Name of street or Highway:_____
8. From which direction were you struck? ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
9. Approximate speed of your car was_____mph. Approximate speed of the other car was_____mph.
10. Were you knocked unconscious? ( ) Yes ( ) No
11. Were police notified? ( ) Yes ( ) No
12. In your own words, please describe the accident. _____

    _____

    _____

    _____

13. Did you have any physical complaints **BEFORE THE ACCIDENT**? ( ) Yes ( ) No

    If yes, please describe in detail. _____

    _____

    _____

14. Please describe how you felt:
    a. **DURING** the accident_____
    b. **IMMEDIATELY AFTER** the accident_____
    c. LATER THAT DAY_____
    d. THE NEXT DAY_____

15. What are your **PRESENT** complaints and symptoms? _____

_____

16. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:

_____

17. Do you have any illnesses that relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

18. Were you taken to the hospital after the accident? ( ) Yes ( ) No Where? _____

19. Have you been treated by another doctor since this accident? ( ) Yes ( ) No Who?_____

20. Since the injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Staying the Same

21. **CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**:

[ ] Headache	[ ] Irritability	[ ] Numbness in Toes	[ ] Face Flushed	[ ] Feet Cold
[ ] Neck Pain	[ ] Chest Pain	[ ] Shortness of Breath	[ ] Buzzing in Ears	[ ] Hands Cold
[ ] Neck Stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of Balance	[ ] Stomach Upset
[ ] Sleep Problems	[ ] Head Seems Heavy	[ ] Depression	[ ] Fainting	[ ] Constipation
[ ] Back Problems	[ ] Pins & Needles in Arms	[ ] Light Bothers Eyes	[ ] Loss of Smell	[ ] Cold Sweats
[ ] Nervousness	[ ] Pins & Needles in Legs	[ ] Loss of Memory	[ ] Loss of Taste	[ ] Fever
[ ] Tension	[ ] Numbness in Fingers	[ ] Ears Ring	[ ] Diarrhea	

Symptoms other than above: _____

_____

22. Have you lost time as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:
a. Last Day Worked: _____ b. Type of Employment: _____c. Present Salary: _____
d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving (e.g. Worker's Comp., State Disability): _____

23. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

24. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

25. Other pertinent information: _____

_____

_____

Date:_____ Signature: _____

Athens Chiropractic Clinic **Patient Present Complaints**

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Social Security# _____ Driver Lic.# _____

Age _____ Birthdate _____ Sex M / F _____ Status M S W D _____ No. Children _____

Occupation _____ Employer _____ Years Employed _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Ext. _____ Referred By: _____

Spouse's Name _____ Occupation _____ Employer _____ Soc. Sec.# _____

Please describe your problem and how it began. ***Date problem began:*** ___/___/_____

_____

_____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ❑ Constantly ❑ Frequently ❑ Occasionally ❑ Intermittently

Describe your current pain/symptoms:	❑ Sharp/Stabbing	❑ Throbbing	❑ Aches
	❑ Dull	❑ Soreness	❑ Weakness
	❑ Numbness	❑ Shooting	❑ Gripping
	❑ Burning	❑ Tingling	❑ Other _____
Since it began, is your problem:	❑ Improving	❑ Getting Worse	❑ No Change
What makes the problem better?	❑ Nothing	❑ Lying Down	❑ Walking
	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ Inactivity/rest	❑ Other _____
What makes the problem worse?	❑ Nothing	❑ Lying Down	❑ Walking
	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ inactivity/rest	❑ Other _____
Can you perform your daily home activities?	❑ Yes	❑ Yes, only with help	❑ Not at all
Do you exercise?	❑ Yes, almost daily	❑ Yes, occasionally	❑ Not at all
Describe your job requirements:	❑ Mainly sitting	❑ Light Labor	❑ Heavy Labor
Can you perform your daily work activities?	❑ Yes, all activities	❑ Only some	❑ Not at all
Describe your stress level:	❑ None to mild	❑ Moderate	❑ High

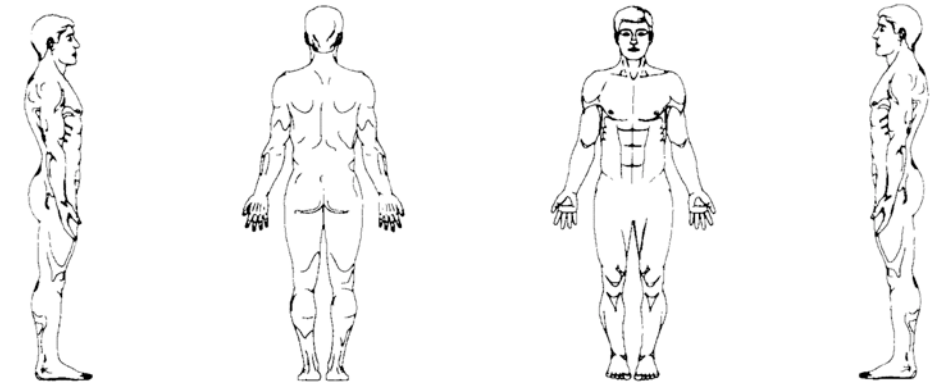
What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

_____

Have you had X-rays, MR or other tests for this condition? What tests and When? _____

_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: _____ Date: _____

Athens Chiropractic Clinic **Patient Health Questionnaire**

Patient Name_____ Patient ID#_____

If you have *ever* had a listed symptom in the *past,* please check that symptom in the *Past Column.* If you are *presently* troubled by a particular symptom, check that symptom in the *Present column.* **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____
☐	☐	Wrist Pain (R_____ L_____
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight
	☐	Gain ☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstral Flow
☐	☐	Profuse Menstral Flow
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date)_____
☐	☐	Stroke (date)_____
☐	☐	Asthma
☐	☐	Cancer, Explain_____
☐	☐	Tumor, Explain_____
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other_____

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other _____
☐ High Blood Pressure_____	

Do you have a permanent disability rating? ☐ **Yes** ☐ **No**

Location_____

Date rating received_____

Rating Percentage_____

Present Weight_____pounds

Height _____feet _____inches

Please check any of the following that apply to you.

☐	☐	Pregnancy, # births_____
☐	☐	Birth Control Pills, type_____
☐	☐	Medications (list if not listed elsewhere)
_____	_____	
☐	☐	Hospitalizations/Surgical Procedures

☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day:_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature:_____ Date: _____