GRICE Chiropractic

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PERSONAL INJURY QUESTIONNAIRE

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: ___/___/_____ SS#: _____ Sex: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____-_____

Employer Data

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-time Student ☐ Part-time Student ☐ Other

Employer: _____

Occupation: _____

Employer Address: _____

Policy Information

Your Ins. Company: _____ Phone Number: (_____)_____

Policy #: _____ Claim #: _____

Responsible Party's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Attorney Information

Name: _____ Phone Number: (_____)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Nature Of Accident

1. Date of Accident: _____ Time of Day: _____
2. Were there any witnesses? ☐Yes ☐No Name(s): _____
3. Were you: ☐Driver ☐Passenger ☐Front Seat ☐Back Seat
4. Number of people in the vehicle: _____ Were you wearing seat belts? _____
5. Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side
6. Approximate speed of your vehicle: _____mph Other vehicle: _____ mph
7. Were you knocked unconscious? ☐Yes ☐No If yes, for how long?: _____
8. Were police notified? ☐Yes ☐No
9. In your own words, please describe the accident: _____

   _____

   _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT? ☐Yes ☐No If yes, please describe:

    _____

    _____

    _____
11. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
12. What are your PRESENT complaints and symptoms? _____

    _____

    _____
13. Do you have any congenital (from birth) factors which relate to this problem? ☐Yes ☐No

    If yes, please describe: _____

    _____
14. Do you have any previous illnesses which relate to this case? ☐Yes ☐No

    If yes, please describe: _____
15. 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: _____

    _____

    _____

16. Where were you taken after the accident? _____

17. Have you been treated by another doctor since the accident? ☐ Yes ☐ No

    If yes, please list doctor's name and address: _____

    _____

    What type of treatment did you receive? _____

    _____

18. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Buzzing in Ears
- ☐ Loss of Balance
- ☐ Fainting
- ☐ Cold Feet
- ☐ Cold Hands
- ☐ Upset Stomach
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Fever
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea

Symptoms other than above: _____

20. Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please fill in below.
    a. Last Day Worked: _____
    b. Type of Employment: _____
    c. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation you are receiving: _____

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

    _____

    _____

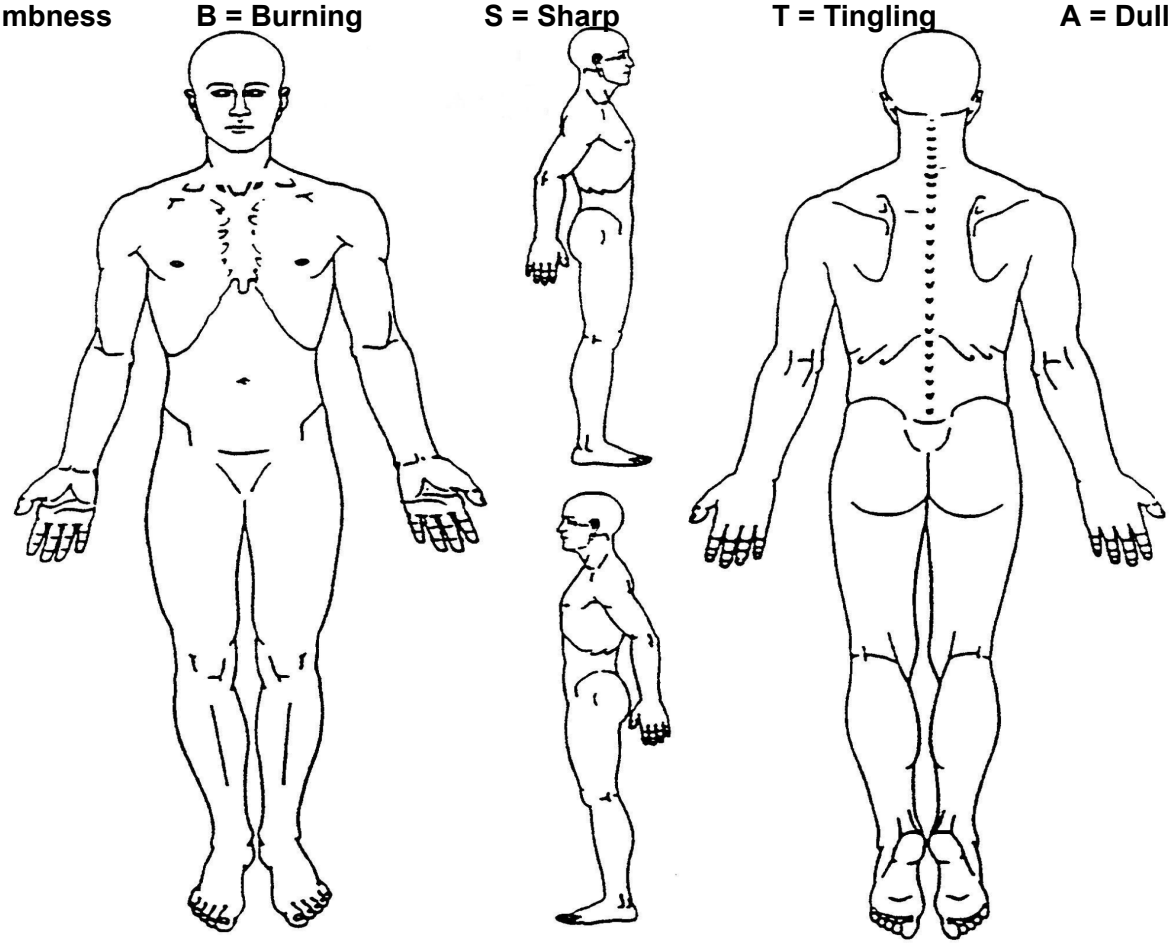
22. Other pertinent information: _____

    _____

    _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness **B = Burning** **S = Sharp** **T = Tingling** **A = Dull Ache**



Average pain intensity:

Last 24 Hours:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain
Past Week:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

Does anything improve your pain? ☐ Yes ☐ No

If Yes, please list: _____

When did your symptoms begin? _____

How did your symptoms begin? _____

_____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling ☐ Throbbing ☐ Other_____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking Short Distance	☐	☐	☐
Sexual Activity	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Bending Forward	☐	☐	☐
Operating Equipment	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Driving	☐	☐	☐
Twisting	☐	☐	☐
Crawling	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Typing	☐	☐	☐

Patient Signature: _____ Date: _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, to whom I am legally responsible) by the doctor or chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other offices or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for a short period of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers, physical therapy,steroid injections, bracing and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contect, and by signing below I agree to the above-named procedures. I intend this content to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____