

# 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.

\_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_ Date \_\_\_\_\_  
 Print Name of Patient, Parent, Guardian or Personal Representative