PERSONAL INJURY QUESTIONAIRE

Name: _____ Date of birth: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employers Name: _____ Employers address: _____

Your Insurance Co: _____ Policy #: _____ Agents Name: _____

Responsible Party: _____ Name: _____ Phone: _____

Do you have a copy of the police report? □YES □NO

In your own words, please describe the accident:

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? □YES □NO

If yes, describe in detail: _____

_____

_____

Please describe how you felt:

a) During the accident: _____
b) Immediately after the accident: _____
c) Later the next day: _____

What are your present complaints and symptoms? _____

_____

_____

Have you ever been involved in an accident before? □Yes □NO

If yes, please describe: _____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? □YES □NO If yes, please list the doctors names and address: _____

What type of treatment did you receive? _____

Have you lost time from work as a result of this accident? □YES □NO If yes, please complete this question:

a) Last day worked: _____
b) Type of employment: _____
c) Are you being compensated for time lost from work? □YES □NO

Do you notice any activity restrictions as a result of this injury? □YES □NO If yes, please describe in detail:

_____

_____

Any other pertinent information: _____

_____

Patient Signature _____ Date _____

IMPORTANT Please X all present symptoms. Rate pain by intensity levels using scale from 0-10.

Absent 0 1 2 3 4 5 6 7 8 9 10 excruciating pain

HEAD:

__Headache (R/L) rate pain (0-10)___
- __sinus (allergy) (0-10)
- __entire head (0-10)
- __back of head (0-10)
- __forehead (0-10)
- __temples (0-10)
- __migraine (0-10)

__Head feels heavy
__Loss of memory
__Light headedness
__Fainting
__Light bothers eyes
__Blurred vision
__Double vision
__Loss of vision
__Loss of taste
__Loss of balance
__Dizziness
__Loss of hearing
__Pain in ears (0-10)
__Ringing in ears
__Buzzing in ears

NECK:

__Pain in the neck (R/L) (0-10)
__Neck pain with movement
- __forward (0-10)
- __backward (0-10)
- __bending right (0-10)
- __bending left (0-10)
- __turning right (0-10)
- __turning left (0-10)

__Pinched nerve in neck
__Neck feels out of place
__Muscle spasms in neck
__Grinding sounds in neck
__Popping sounds in neck
__Arthritis in neck

MIDBACK (blade area)

__Mid-back pain (R/L) (0-10)
__Pain in between blades (R/L) (0-10)
__Sharp stabbing
__Dull ache
__Pain in kidney area (0-10)
__Muscle spasms (R/L)

ARMS & HANDS:

__Pain in upper arm (R/L) (0-10)
__Pain in elbow (R/L) (0-10)
__Pain in forearm (R/L) (0-10)
__Pain in hands (R/L) (0-10)
__Pain in fingers (R/L) (0-10)
__Pins and needles sensation
- __arms (R/L)
- __hands/fingers (R/L)

__Numbness
- __arms (R/L)
- __hands/fingers (R/L)

__Pain aggravated by movement
__Tennis elbow (R/L)
__Hands feel cold
__Swollen fingers
__Loss of grip strength (R/L)
__Arthritis
__Shoulders (R/L)
__Elbow (R/L) __Fingers (R/L)

SHOULDER JOINTS:

__Pain in shoulder joint (R/L) (0-10)
__Pain across shoulders (0-10)
__Bursitis (R/L)
__Arthritis (R/L)
__Can't raise arm
- __above shoulder level
- __above head

__Tension in shoulders
__Pinched nerve in shoulder (R/L)
__Muscle spasms in shoulders (R/L)

CHEST:

__Chest pain (0-10)
__Shortness of breath
__Pain around ribs (0-10)
__Breast pain (0-10)
__Dimpled/ orange peel breast

ABDOMEN:

__Nervous stomach
__Nausea
__Gas
__Constipation
__Diarrhea
__Hemorrhoids
__Foods can't eat _____

LOW BACK:

__Upper lumbar (R/L) (0-10)
__Lower lumbar (R/L) (0-10)
__Sacroiliac (R/L) (0-10)
__Low back pain is worse when:
- __working (0-10)
- __lifting (0-10)
- __stooping (0-10)
- __standing (0-10)
- __sitting (0-10)
- __bending (0-10)
- __coughing (0-10)
- __lying down (sleeping) (0-10)
- __walking (0-10)
- __low back feel better_____
- __slipped disc

Pain from front to back
- __Low back feels out of place
- __Muscle spasms
- __Arthritis

HIPS, LEGS & FEET:

__Pain in buttocks (R/L) (0-10)
__Pain in hip joints (R/L) (0-10)
__Pain down leg (R/L) (0-10)
__Knee pain (R/L)
- __inside/medial (R/L) (0-10)
- __outside/lateral (R/L) (0-10)
- __Leg cramps (R/L) (0-10)
- __Foot cramps (R/L) (0-10)

__Pins & needles sensation in legs (R/L)
__Numbness
- __Legs (R/L)
- __Feet (R/L)
- __Toes (R/L)

__Swelling
- __Legs (R/L)
- __Ankles (R/L)
- __Feet (R/L)

__Feet feel cold (R/L)

WOMEN ONLY:

__Menstrual pain (where)_____(0-10)
__Cramping (severe/ mod/ mild)
__Irregularity
__Cycle _____ days
__Birth Control _____type
__Hysterectomy _____year
- __Complete
- __Partial

__Hormone replacement therapy
__Genital Cancer
__Discharge _____color
_____Treatment
__Tumors
__Fibroids
__Menopause
- __Premenstrual Syndrome
- __Abortions

MEN ONLY:

__Frequent urination
__Difficulty in starting
__Difficulty in emptying completely
__Frequent night urination
__Prostate cancer (year diagnosed _____)
__treatment _____
__Enlarged Prostate

GENERAL:

__Nervousness
__Irritable
__Depressed
__Fatigue
__Feel run-down
__Arthritis
__Osteoarthritis
where _____
__Rheumatoid
__Gout
__Fibromyalgia
__Diabetes
- __Insulin dependent
- __Non-insulin dependent
- __Blood sugar
- __control thru diet and exercise only
- __Hypoglycemia

__Normal hours of sleep_____
__Lost hours of sleep_____
__Weight gain_____lbs. 1/3/6/12 months
__Weight loss_____lbs. 1/3/6/12 months
__Soda____12oz. cans/day type_____
cola/non-cola/diet/caffeine free
__Coffee/Tea___cups/day____Decaf
__Cigarettes_____packs/day
__Vitamins (list) _____
_____

REMARKS:

_____

_____

_____

Past History:

1: If you have ever experienced any of the following conditions at any time please mark with an X:

(even if it seems as insignificant as falling off the monkey bars as a child)

___Moving Vehicle Accident ___Injury: Lifting/Falling, etc. ___Broken Bones

___Heart Attack ___Convulsions/Epilepsy ___Vascular Issues

___Disability ___Jaw Pain/TMJ ___Tremors

___Stroke ___Cancer

Social History:

1: Height_____ Weight_____ Blood Pressure_____/_____

2: Smoking: Cigars Pipe Cigarettes (Circle one) How often? Daily Weekends Occasionally Never

3: Alcoholic beverage: Consumption occurs… Daily Weekends Occasionally Never

4: Recreational Drug use: Daily Weekends Occasionally Never

5: List prescription drugs you take:

_____

_____

6: Allergies to prescription drugs:

_____

_____

7: List Vitamins and Supplements or non-prescription drugs you take:

_____

_____

Family History:

1: Does anyone in your family suffer the same condition(s) you currently have? **Yes/No** (if yes whom)

Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)

Have they ever been treated for their condition? **Yes No I Don't Know**

2: Any other hereditary conditions the doctor should be aware of? **Yes/No** (if yes what)

_____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO GEM CITY CHIROPRACTIC FOR ALL BENEFITS WHICH MAY BE PAYABLE UNDER A HEALTHCARE PLAN OR FROM ANY OTHER COLLATERAL SOURCES. I AUTHORIZE UTILIZATION OF THIS APPLICATION OR COPIES FOR THE PURPOSE OF PROCESSING CLAIMS ND EFFECTING PAYMENTS. I ALSO FURTHER ACKNOWLEDGE THAT THIS ASSIGNMENT OF BENEFITS DOES NOT IN ANY WAY RELIEVE ME OF PAYMENT LIABILITY AND THAT I WILL REMAIN FINANCIALLY RESPONSIBLE TO GEM CITY CHIROPRACTIC FOR ANY AND ALL SERVICES AT THE OFFICE.

_____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON DATE COMPLETED

NAME: _____

DATE: _____

ACTIVITIES DISCOMFORT SCALE

In the boxes below, mark the appropriate statements with an "X".

Activity	Doesn't Hurt At All	Hurts A Little (1, 2, 3)	Hurts Moderate (4, 5, 6)	Hurts Severly (7, 8, 9, 10)	Unbearable Pain Prevents Activity
1.Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing stairs					
9. Carrying					
10. Pushing and pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household chores					
16. Gardening					
17. Sports					
18. Employment					

Name: _____ Date: _____ Doctor: _____

Date of Accident: _____ Time of Accident: _____

Patient Role
Driver
Front passenger
Rear passenger
Motorcycle operator
Motorcycle passenger
ATV operator
Other

Other Vehicle Size
Not reported
Subcompact
Compact
Mid-Size
Full-Size
Other

Time of Day
Not reported
Daylight
Dawn
Dusk
Night
Other

Patient Struck
Not reported
Steering wheel
Air bag
Dashboard
Rear-view mirror
Windshield
Car interior
Other

Patient Conscious
Not reported
Lost consciousness
Did not lose
Consciousness

Vehicle Size
Not reported
Subcompact
Compact
Mid-size
Full-size
Other

Other Travel Directions
Not reported
North
South
East
West
Other

Injury Area
Head
Neck
Shoulders
Upper/Mid-back
Lower back
Chest/Ribs
Arms
Elbows
Forearms
Wrists
Hands
Abdomen
Buttocks
Pelvis
Hips
Thighs
Legs
Knees
Ankles
Feet

Road Conditions
Not reported
Dry
Damp
Wet
Snow
Icy
Other

Lap Belt
Not reported
Used
Not used

Shoulder Belt
Not reported
Used
Not used

Collision Location
Not reported
Head on
Front
Behind
Passenger Side
Driver Side
Other

Head Rest
Not reported
Above head
Below head
None

Travel Direction
Not reported
North
South
East
West
Other

Air Bags
Not reported
Deployed
Did not deploy

Accident Anticipated
Not reported
Yes
No

Patient Ejected
Not reported
Ejected
Not Ejected

Circle symptom that you have noticed since the accident:

Headache	tension	chest pain	fever	pins and needles in arms
Neck pain	feet cold	dizziness	fainting	pins and needles in legs
Neck stiff	cold sweats	loss of memory	diarrhea	sleeping problems
Back pain	depression	loss of smell	constipation	
Nervousness	irritability	hands cold	fatigue	

GEM CITY CHIROPRACTIC
521 South 24th Street
Quincy, IL 62301

NOTICE OF HEALTH CARE PROFESSIONAL LIEN

Date: _____
Provider: Gem City Chiropractic, LLC

Date of accident: _____
Licensed Illinois Physician:
Dr. Becky Grimm
Gem City Chiropractic, LLC
521 South 24th St.
Quincy, IL 62301
Phone: (217) 222-4363

Patient: _____
Address: _____
City/State/Zip: _____

Liable Party: _____
Address: _____
City/State/Zip: _____

If injured person is a minor or disabled adult,
Name of parent or responsible party:
_____

Insurance Co: _____
Address: _____
City/State/Zip: _____
Claim #: _____

Insurance Co: _____
Address: _____
City/State/Zip: _____
Claim #: _____

YOU ARE FORMALLY ON NOTICE THAT WE HAVE A LIEN UPON ALL CLAIMS AND CAUSES OF ACTION IN THIS CASE FOR ALL MEDICAL SERVICES RENDERED, PROVIDED THAT THE TOTAL AMOUNT OF ALL LIENS SHALL NOT EXCEED ONE-THIRD (1/3) OF THE SUM PAID OR DUE TO THE INJURED PERSON ON THE CLAIM OR RIGHT OF ACTION. YOU ARE INSTRUCTED TO PAY US DIRECTLY FOR THE CARE THIS PATIENT NEEDED IN TREATMENT OF THEIR ACCIDENT RELATED INJURIES.

If you need any additional information, please do not hesitate to contact our office.

SIGNED: _____ DATE: _____
Patient or responsible party

SIGNED: _____ DATE: _____
Witness

SIGNED: _____ DATE: _____
Doctor

Sincerely,
Gem City Chiropractic
Notices Served Registered Mail or Certified Mail

Patient _____
if patient is a minor or disabled adult,
parent or responsible party _____
Liable party _____
Medical Pay Ins. _____
Liable Insurance Co _____