



PERSONAL INJURY QUESTIONNAIRE

Legal Name: _____ Date: _____
Address: _____ City: _____
State: _____ Zip: _____ Birthdate: ___/___/___ SS#: _____-____-____ Sex: ()F ()M
Email: _____
Cell Phone: _____ Work Phone: _____
Emergency Contact: _____ Phone Number: _____

Your Auto Insurance Information

Auto Ins. Co.: _____ Claim #: _____
Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Adjuster's Phone #: _____
Policy Holder's Name (if other than self): _____

Accident Details

Date of accident: _____ Time of day: _____ Were you struck from: Behind Front Left Right
Headrest position at impact? Bottom of head Bottom of Neck Middle of head
Number of people in vehicle: _____ Were you wearing a seat belt? ()Y ()N
Were you: Driver or Passenger? Were you in the *front seat* or *back seat*?
Approx speed of your car: _____mph Approx speed of other car: _____mph
Were you knocked unconscious? _____ *If yes, for how long?* _____ Were the airbags deployed? _____
Were the police notified? ()Y ()N Do you have an accident report? ()Y ()N *please provide a copy
Was a traffic violation issued? ()Y ()N *If yes, to whom:* _____
Were you treated at the scene by paramedics? ()Y ()N *Were you taken to the hospital* ()Y ()N
Did you have to go to the ER or a doctor in the days following the accident ()Y ()N
Were there witnesses? If so, please name: _____

In your own words, please describe the accident: _____

Did you have any physical complaints before the accident? () Yes () No

If yes, please describe: _____

Please describe how you felt:

During the accident _____

Immediately after the accident _____

Later that day _____

Have you been treated by another doctor since the accident? () Y () N

If yes, please write down their names: _____

Since the injury occurred, are your symptoms () improving () getting worse () the same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|---|---------------------------------------|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Flushed face | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heavy Head | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Nervousness | | <input type="checkbox"/> Pin/Needles in legs | | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Numbness in fingers | | <input type="checkbox"/> Pins/Needles in arms | | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Light Sensitive Eyes | | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ |

Have you ever been involved in an accident before? () Y () N

If yes, please describe, including dates and types of accidents as well as injuries suffered:

Have you lost time from work as a result of this accident? () Y () N If yes, last day worked: _____

Type of Employment: _____ Place Of Employment: _____

Did you notice any activity restrictions as a result of this injury? () Y () N

If yes, please describe: _____

General Symptoms Sheet

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

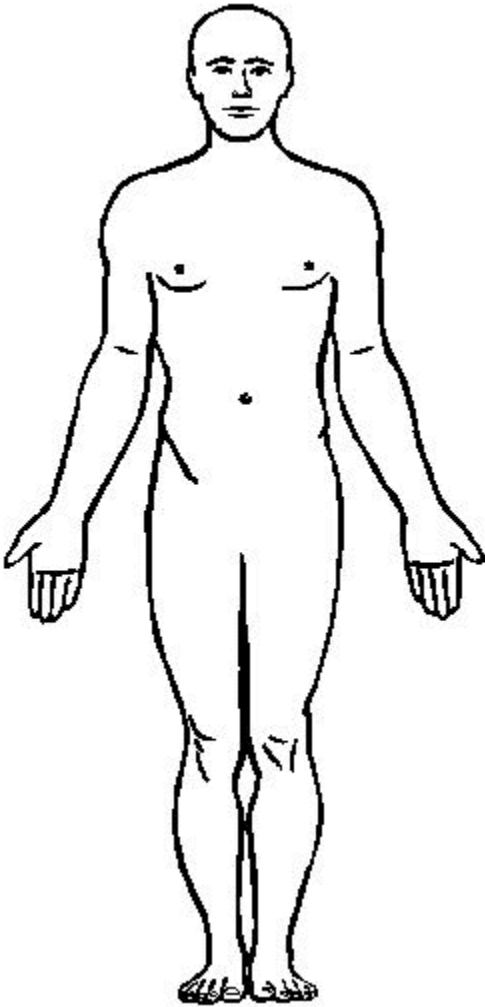
M = SPASMS

F = STIFFNESS

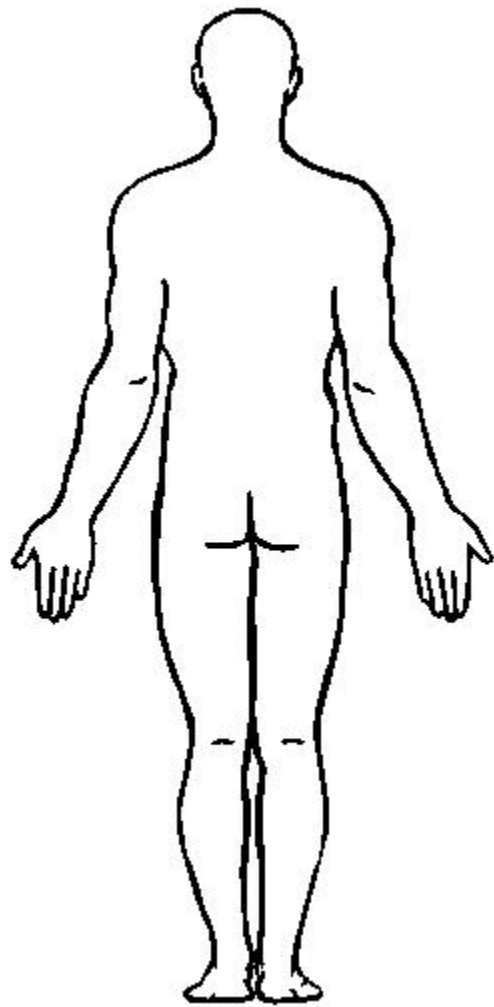
N = NUMBNESS

T = TINGLING

O = OTHER



FRONT



BACK

If you marked "O" for OTHER on any part, please explain below:

QUADRUPLE VISUAL ANALOGUE SCALE

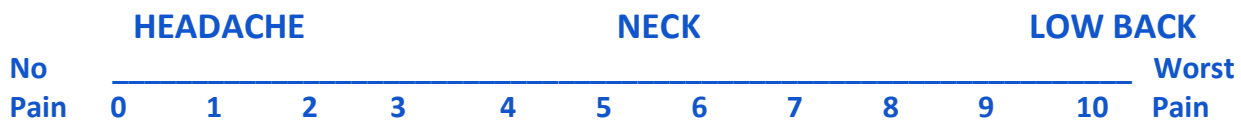
Name _____

Date _____

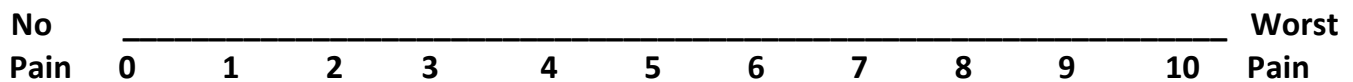
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

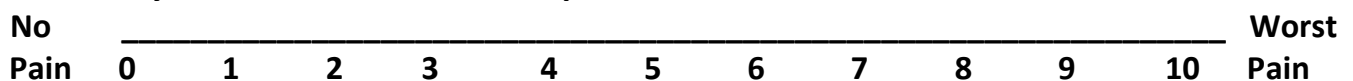
EXAMPLE:



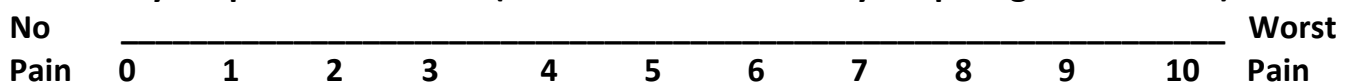
1. What is your pain RIGHT NOW?



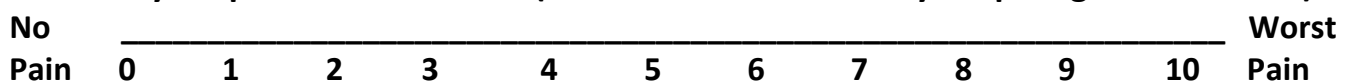
2. What is your TYPICAL or AVERAGE pain?



3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



PERSONAL INJURY OFFICE POLICY

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled. Please initial where indicated and sign below that you have read and understand this policy.

Responsibility for Accident

If you were involved in an auto accident, that you were responsible for, in your own vehicle, we will bill the medical portion of your car insurance policy (if available) for services rendered in our office. If you were a passenger in another vehicle, the car insurance company that insures that vehicle may be billed for the charges of your medical services.

If another vehicle, other than the vehicle you traveled in, caused the accident, we will first bill that auto insurance for medical services rendered. If neither your car insurance policy nor the responsible party's car insurance policy does not include medical coverage, we will require that you obtain an attorney and sign a lien. We can recommend an attorney if you do not have one. By signing the lien we agree, as a courtesy to you, to defer payment of your medical bills until your settlement is received. If you use an attorney, all bills will be submitted to the attorney to settle your case. We will not bill any auto insurance company if you have an attorney. If you switch attorneys during or after your care with us, you are to notify us immediately and provide the contact information of your new attorney. If care is discontinued before your treatment plan is complete, payment of your account is due immediately. This office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

_____ ***Your initials***

Responsibility for Payment

If you already have an attorney, please provide the name and contact info on the sheet provided. Ask your attorney to send us a letter of representation. A release packet including your bills and records will be sent to your attorney after your release exam. If you do not plan to retain an attorney and are, instead, filing claims to an insurance company, you will need to contact the insurance company and provide us with all information for billing including name, contact information and claim number. No bills or copies of bills will be given to you until the attorney or insurance company has signed a lien or letter of protection to protect the interest of Restore Health. As a courtesy to you, we will provide your insurance company and/or attorney with all the information they need to negotiate and provide payment for any charges you incur in our office. However, all charges for services rendered in our office are charged directly to you and ultimately you are personally responsible for payment of these charges.

_____ ***Your initials***

Cancellation & No-show Policy

Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. If it is necessary to miss an appointment, we request that you make the appointment up, within 24 hours, if possible. Patients who miss 3 consecutive visits without calling this office will be discharged from care. Your claim will be closed out and bills submitted to the appropriate insurance company or the attorney listed on your patient intake form.

_____ ***Your initials***

I hereby authorize and direct my attorney or insurance company to pay to Restore Health such sums as may be due for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Restore Health. And I hereby further request that payment be made directly to Restore Health which would otherwise be paid to myself, as the result of the treatment charges injured for the injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim. I understand that I am directly and fully responsible for all medical bills submitted for services rendered me and that this agreement is made solely for the protection and in consideration Restore Health for awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover. Please acknowledge your agreement to this request by initialing above and signing below.

Date	Patient's Name	Signature	Date of Injury
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Complete Below If You Are Using An Attorney

**RESTORE HEALTH
903 Dukes Street St. George SC 29477**

NOTICE OF LIEN

Letter of Protection / Irrevocable Assignment of Benefits

Name: _____ Date of Accident: _____

Parent / Guardian (If Minor): _____

Attorney's Information:

Name: _____ Law Firm: _____

Address: _____

Phone: _____ E-Mail: _____

I, _____, do hereby authorize this office to furnish the above listed attorney with a full report of my examination, diagnosis, treatments, prognosis etc., in regard to the accident in which I was involved.

I hereby direct my attorney to withhold the full amount for the billed charges in connection to this accident. I hereby notify my attorney that I have a lien from the above provider's office in consideration of their willingness to treat me on credit without demand for payment at the time services are rendered. I instruct my attorney to pay for all services rendered directly to the provider, Restore Health, within 14 days of my case settlement. I understand that any settlement, verdict, or judgment cannot be distributed to me without first satisfying this lien.

I agree to promptly notify Restore Health 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 substituted or added attorney(s). 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.

I understand that the bills which I incur at Restore Health are my responsibility. I acknowledge that this office will **not** bill to my health insurance companies but that I can submit bills myself for reimbursement, if any. I further agree that if the proceeds from the accident are not enough to satisfy my bill, Restore Health reserves the right to pursue collection of any outstanding balance.

Date: _____ Patient / Legal Guardian Signature: _____

Date: _____ Staff/Witness Signature: _____

THE UNDERSIGNED ATTORNEY AND HIS/HER FIRM ACKNOWLEDGES AND HEREBY AGREES TO OBSERVE ALL THE TERMS ABOVE AND AGREES TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT, AS MAY BE NECESSARY TO ADEQUATELY PROTECT AND FULLY COMPENSATE RESTORE HEALTH. ATTORNEY FURTHER AGREES TO PAY RESTORE HEALTH DIRECTLY OUT OF THE PROCEEDS FROM THE SETTLEMENT AND NOT AFTER DISTRIBUTION TO THE PATIENT. ATTORNEY AGREES TO MAKE PAYMENT DIRECTLY TO RESTORE HEALTH.

Date: _____ Attorney's Signature: _____

Attorney: Please sign/date and return original to this office and retain a copy for your records.

Complete If You Are NOT Using An Attorney And Are Filing Directly To An Insurance Company

**RESTORE HEALTH
903 Dukes St St. George SC 29477**

Insurance / Assignment of Benefits

Name: _____ Date of Accident: _____

Parent / Guardian (If Minor): _____

LIABILITY INFORMATION:

Health Insurance Name: _____ Policy #: _____
(Please provide this office with a copy of your health insurance card)

OR

Auto Insurance Name: _____ Policy #: _____
(Please provide this office with a copy of your auto insurance card)

Agent or Adjustor's Name: _____ Phone: _____

Claim # For This Accident: _____

RESPONSIBLE PARTY INFORMATION (If NOT Patient):

Name of Responsible Party: _____ Phone: _____

Auto Insurance Name: _____ Policy #: _____

Agent or Adjustor's Name: _____ Phone: _____

Claim # For This Accident: _____

I, _____, do hereby authorize this office to furnish the above listed insurance company, with a full report of my examination, diagnosis, treatments, prognosis etc., in regard to the accident in which I was involved.

I hereby direct the insurance company to withhold the full amount for the billed charges in connection to this accident. I hereby notify the insurance company that I have a lien from the above provider's office in consideration of their willingness to treat me on credit without demand for payment at the time services are rendered. I instruct the insurance company to pay for all services rendered directly to the provider, Restore Health. I understand that any settlement, verdict, or judgment cannot be distributed to me without first satisfying this lien. I clearly understand that the bills which I incur at Restore Health are my responsibility.

Date: _____ Patient / Legal Guardian Signature: _____

Date: _____ Staff / Witness Signature: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Restore Health have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature

Date

X-RAYS/ Imaging Studies Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files.

At your request, we will provide you with a copy of your x-rays.

PLEASE NOTE: X-Rays are used in this office to help locate and analyze vertebral subluxations.

These X-Rays are not used to investigate for medical pathology. The Doctor at Restore Health does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

Signature of Patient

Date

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT RESTORE HEALTH.

Signature of Patient

Date

Medical Information Release Form (HIPPA Release Form)

Name: _____ Date of Birth: _____

Release of Information:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

The *Release of Information* will remain in effect until terminated by me in writing.

Messages:

Please call my home my work my mobile number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____

Date: _____