NATURAL HEALTH CENTER, P.C.

PERSONAL INJURY QUESTIONNAIRE

Date ________________________

Dear Patient:

We need this confidential information answered completely to help us assess your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

GENERAL INFORMATION:

Name ____ SS # ____________________________

Date of Birth ________________________________ Male _____ Female _____

NATURE OF ACCIDENT – Please explain in detail how your accident happened:

1. What was the time and date of this present injury? _______AM _____PM _________________, 20_____
2. Please explain in detail how your accident happened. (Please include location and conditions.) _________________
 ____
 ____
3. Did you come in contact with any objects? __________ If yes, what objects (i.e. door, cabinet?) ______________
 ____
4. What parts of your body came in contact with the above object(s)? ______________________________________
5. Where did you feel pain or unusual feeling immediately after the accident? ________________________________
6. Were you unconscious as a result of the injury? _____ If yes, how long? __________________________________
7. Were you bleeding as a result of the injury? ____
8. Did you consult any other doctor ? _____ If so, where? ____
 Treating Doctor's name ____ DC ___ MD ___ DO ___ DDS ___
9. Describe the doctor's diagnosis ____
10. What treatment did you receive? ____
11. Are you still under a doctor's care? ____ If yes, please explain ____
 ____

PAST HISTORY:

1. Have you ever injured this area before?______ If yes, when? ______________________________________
2. If injured before, did you lose time from work? ____

(CONTINUED ON BACK)

3. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? _______ If yes, please explain dates and details?_______________________________________

____

____

4. Have you been treated previously by a chiropractor? ____ If yes, please explain? ____________________________

____

PRESENT INFORMATION/DISABILITY:

1. Have you returned to work? _________ If yes, date returned to work? ________________________________
2. Job description____
3. Do you have to favor any part of your body in your work? ___________ If yes, please explain? _______________________

   ____
4. Before the injury, were you capable of working on an equal basis with others your age?____________________
5. Are your work activities restricted as a result of this accident? ________ If yes, please explain?____________________

   ____
6. Since this injury, are your symptoms: improving_____________ , getting worse____________ or the same? __________

   Please explain? ____

   ____
7. Do any diseases or accidents affect your employment?____________If yes, please explain? _______________________

   ____

LEGAL REPRESENTATION:

1. Have you retained an attorney? _______________ If yes, name and address? ____________________________

   ____

INSURANCE COMPANY:

1. Name of Insurance Company ____________________________________ Address______________________________

   _______________________________________ Claim #______________________________________

   Contact Name ____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ ________________________

Patient's Signature Date

____ ________________________

Doctor's Signature (upon review) Date