



Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ___/___/___

Social Security Number: ___-___-___ Birth Date: ___/___/___ Age: ___ Gender: F M

Current Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Email Address: _____

Marital Status: Single Married Separated Widowed

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ / /
- 2) _____ / /
- 3) _____ / /

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

- | | | | | | |
|--|--|--|---------------------------------|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizure Disorder |

Other: _____

Basic Information about the Accident:

Date Accident Occurred: ___/___/___ Time: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Describe your pain: Burning Sharp Dull Ache

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- | | | | | | |
|--|--|--|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Chest pain/rib pain | <input type="checkbox"/> Pain in arms/hands | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Jaw pain | |
| <input type="checkbox"/> Loss of strength - arms | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sharp/shooting pain | |

Have you experienced changes to:

- | | | | | |
|---------------------------------------|---|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Ears (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Emotion | <input type="checkbox"/> Appetite | | | |

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Other _____

Auto-Accident Specific Information:

Were you the: Driver Passenger Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Where did the accident happen? Street Names: _____ City/State _____

Was it? Controlled Intersection Uncontrolled Not Intersection

Was there a traffic light? None Green Red Turn Arrow Stop Sign

Were you: Slowly Moving Moving Stopped

Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other _____

Type of Impact: Rear end Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on brake

How far did your car move? Did not move Moved 1-5 ft Moved 6-10 ft Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? Yes No

Shoulder harness: Yes No Headrest: Yes No Headrest Position: Up Down

Is the car equipped with airbags? Yes No Did they deploy? Yes No

Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

On impact, your head was looking: Ahead Behind Up Down To the Right To the Left

On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____

Did your body hit anything inside the car? Yes No Body Part: _____

What did it hit? _____

Head trauma? Yes No Loss of Consciousness? Yes No For how long? _____

Do you remember the accident happening? Yes No

Hospital? Yes No Name of hospital: _____ How long there? _____

Taken by ambulance? Yes No

X-rays taken? Yes No X-ray areas: Neck Mid-back Low-back Other X-rays _____

Medication Given? Yes No RX: _____

Other instruction: _____ Follow-up: _____

CONSENT FOR TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on a minor in my care.

by the licensed doctors of chiropractic, and/or certified assistants who may be employed by or engaged in practice in this clinic. I will have an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment, based upon facts known, that is in my best interests.

By signing, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient/Guardian Signature _____ Patient
Name _____

Date ____/____/____

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/____

PRIVACY NOTICE

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) and ACKNOWLEDGEMENT OF RECEIPT OF A COPY OF OUR PATIENTS RIGHTS AND PATIENT RESPONSIBILITIES POLICIES.

I acknowledge that a copy of Midtown Chiropractic & Acupuncture's Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I FURTHER Acknowledge that I have received a copy of Midtown Chiropractic & Acupuncture's Patient Rights and Patient Responsibilities Policies.

Signature: _____ Date: ____/____/____



chiropractic & acupuncture

1705 Pacific Drive

Raleigh, NC 27609

Phone: 919-873-2225

Fax: 919-615-3910

www.raleighmidtownchiropractic.com

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: _____.

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient's Signature: _____ Date: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Date: _____

Please sign, retain a copy for your records, and return this copy to us promptly.



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RECORD RELEASE AUTHORIZATION

DOCTOR/HOSPITAL _____

ADDRESS _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS (please include a copy of X-Ray film & CD) TO:

Midtown Chiropractic & Acupuncture
1705 Pacific Drive
Raleigh, NC 27609

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Signature of Parent or Legal Guardian (If patient is a minor): _____

Witness (to the signature): _____