ST. PAUL CHIROPRACTIC
& Natural Medicine Center.

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?

☐ **Driver:** Were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

☐ **Passenger:** Were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike another vehicle ☐ Yes ☐ No

Was your vehicle struck by another vehicle ☐ Yes ☐ No

First Collision: ☐ Front ☐ Back ☐ Left ☐ Right

If Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right

Were you wearing a seat belt? ☐ Yes ☐ No

Did you brace for impact? ☐ Yes ☐ No

Which way were you facing at the time of impact… ☐ straight ☐ Left ☐ Right

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify what part of your body struck what: (i.e. Head, Chest, Chin, Shoulder, Knee…Right/Left)

☐ Steering Wheel _____ ☐ Dashboard _____

☐ Windshield _____ ☐ Roof _____

☐ Left Side Door _____ ☐ Right Side Door _____

☐ Left Side _____ ☐ Right Window _____

☐ Other _____

Did the seat back bend or break? ☐ Yes ☐ No

Immediately following the accident, how did you feel? ☐ Dizzy/dazed ☐ Disoriented

☐ Unconscious ☐ Nervous ☐ Nauseous ☐ Upset ☐ Weak ☐ Other _____

Did you go to hospital? ☐ Yes ☐ No

Were you admitted to the hospital? ☐ Yes ☐ No If yes how long? _____

If you went to hospital, when? ☐ At time of accident ☐ Next day ☐ Other _____

How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Name of Hospital: _____

Attended by Dr. _____

What treatment was given?

☐ None ☐ Placed in a cervical collar ☐ X-rayed ☐ Given stitches ☐ Bandaged

☐ Given pain medication ☐ Given instructions regarding concussions

☐ Given instructions regarding sprains and strains ☐ Physical Therapy

☐ Instructed to call a Orthopedic Surgeon ☐ Instructed to call a private physician

☐ Referred to this office for treatment ☐ Other _____

_____

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Name: _____ **Date:** _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name and contact information:

CHIEF Complaints or Symptoms:

Select any areas of radiation ☐ NONE	☐ Left Shoulder ☐ Left Arm ☐ Left Forearm ☐ Left Hand ☐ Right Shoulder ☐ Right Arm ☐ Right Forearm ☐ Right Hand			
☐ **Neck Pain**	☐ NONE	☐ Left	☐ Right	☐ Bilateral
☐ Headache	☐ NONE	☐ Left	☐ Right	☐ Bilateral
☐ Migraine Headache	☐ NONE	☐ Left	☐ Right	☐ Bilateral
☐ Upper Back Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral

Ringing in Ears	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Ears	
Blurry Vision	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Eyes	
Wrist Pain	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Wrists	
Jaw Pain	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Sides	

☐ Dizziness ☐ Nervousness ☐ Fatigue ☐ Anxiety ☐ Depression ☐ Excessive Irritability
☐ Fear of driving in a car ☐ Loss of concentration ☐ Jaw clenching ☐ Grinding of teeth at night
☐ Nightmares ☐ Difficulty with sleeping at night

Select any areas of radiation ☐ NONE	☐ Buttocks ☐ Left buttock ☐ Left thigh ☐ Left knee ☐ Left foot ☐ Right buttock ☐ Right thigh ☐ Right knee ☐ Right foot

Mid-Back Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral
Low Back Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral
Hip Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral
Knee Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral
Foot Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral
Foot Pain	☐ NONE	☐ Left	☐ Right	☐ Bilateral

Numbness:

☐ Left Hand ☐ Left Upper Arm ☐ Right Hand ☐ Right Upper Arm
☐ Left Foot ☐ Left Leg ☐ Right Foot ☐ Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐ Yes ☐ No
If yes please give dates: _____ Type of employment: _____
Have you had previous injuries or accidents? ☐ Yes ☐ No
Description of previous Accident: _____
Description of previous injuries: _____
Is there any residual pain from the previous injury? ☐ Yes ☐ No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

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Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

_____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Date of last GYN exam_____

Mammogram ☐ + ☐ -

PAP ☐ + ☐ -

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section_____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____days

Interval of time between cycles _____days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

_____

Health Habits

☐ Tobacco:

Cigarettes: #/day_____

Cigars: #/day _____

☐ Alcohol:

Wine: #glasses/d or wk_____

Liquor: #ounces/d or wk_____

Beer: #glasses/d or wk _____

☐ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d_____

Other sources_____

☐ Water: #glasses/d_____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk - #days/wk _____
- ☐ Run, jog, other aerobic - #days/wk

_____

- ☐ Weight lift - #days/wk_____
- ☐ Stretch - #days/wk _____

Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

☐ Skip meals - which ones _____

_____

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other _____

_____

I Would Like To:

ENERGY - VITALITY

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

BODY COMPOSITION

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

LIFE ENRICHMENT

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

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Financial Policy

Regarding Insurance Coverage

- **Auto accidents:** In most cases, auto insurance pays 100% for care related to your auto injury. You must notify your insurance company or agent that you are under care at our office, and complete their " Application for Benefits" immediately. If your policy has a deductible, you will be responsible for paying that amount as services are received unless other arrangements are made with our office.

- **Major medical:** Your insurance company may deny payment for the service provided to you for the following reason: **That the particular service received may not be reasonable and necessary under my insurance companies standards.**

For this reason, please read and sign the following statement:

"I have been informed by my physician that he believes that, in my particular case, my insurance may deny payment for the services for the reasons stated. If my insurance denies payment I agree to be personally and fully responsible for payment of said services."

- **Medicare:** Medicare pays a portion of the manipulation charge after the deductible has been met (spinal manipulations only). Medicare does not pay for examinations, x-rays, physiotherapy, nutritional supplements, exercises, consultations, laboratory tests, or orthopedic supports. *****Additional Medicare ABN form must be signed*****

- **Worker's compensation:** In most cases, workers compensation insurance pays 100% for care related to your injury. You must notify your employer that you are under care at our office immediately. In general, 12 weeks of care is covered.

Agreement

I have read and understand the above financial policy. I understand that, whether I have insurance coverage or not, I am personally responsible for payment of all charges for services rendered to me. Payment is due the day the service is performed unless other arrangements have been made. I hereby consent to examination, x-rays, and treatment, if needed.

I hereby authorize my attending doctor to release to my insurance company any information concerning my examination or treatment. I understand that St Paul Chiropractic & Natural Medicine Center may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any co-pays, deductibles and coinsurance at the time of service. I hereby assign all benefits paid as a result of claims submitted on my behalf to St Paul Chiropractic & Natural Medicine Center. In the event this account is placed with an attorney or collection agency, I am responsible for collection fees, attorney's fees, and court costs

Signature: _____ Date: _____

Witness: _____ Date: _____

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Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record to get more information about it by contacting St Paul Chiropractic & Natural Medicine Center.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

You may refuse to sign this acknowledgement

By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____

Patient or legally authorized individual Date Time

_____

Printed name if signed on behalf of patient Relationship

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

This box intended for office staff only

Individual refused to sign:

- ⊗ Communication barriers prohibited obtaining acknowledgement
- ⊗ An emergency situation prevented us from obtaining acknowledgement
- ⊗ Other (Please Specify) _____

_____

Additional Disclosure Authority

⊗ *No other spouse, family member, or friend my have access to my health information.*

In addition to the allowable disclosures described in the "Notice if Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below:

Any member of my immediate family: Yes____ No ____

Spouse only: _____ Yes____ No____

Other: (Please Specify)_____ Yes____ No____

Relationship to patient: _____

Name: _____

Signature: _____ **Date:** _____

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Informed Consent to Chiropractic Treatment

The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel/hear a "click", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, soft tissue therapies, exercise instruction, and acupuncture may also be used.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

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