PERSONAL INJURY QUESTIONNAIRE

Name_____Phone ( )_____

Address _____City_____State_____Zip _____

Age _____ Birthdate_____Sex_____S/S # _____

Employers Name _____Employers Address_____

Your Car Ins. Company _____ Claim # _____

Adjustor's Name _____ Adjustor's Phone Number_____

Other Person's Car Ins. Company _____ Claim # _____

Adjustor's Name _____ Adjustor's Phone Number_____

Attorney Name_____Phone ( )_____

Address _____City_____State_____Zip _____

Were there any witnesses ( ) Yes ( ) No Was anyone Cited ( ) Yes ( ) No If so, who? _____

NATURE OF ACCIDENT

1. Date of Accident _____Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?_____Were you wearing seat belts?_____ _____
4. Make of vehicle you were in? _____ Model of vehicle you were in? _____
5. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street)_____ _____
6. What direction was other vehicle headed ? ( ) North ( ) East ( ) South ( ) West
   On (name of street)_____ _____
7. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
8. Approximate speed of your car _____mph Other car _____mph
9. Were you knocked unconscious? ( ) Yes ( ) No If yes , for how long_____
10. Were police notified? ( ) Yes ( ) No
11. In your own words, please describe accident: _____

    _____

    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

    _____

    _____

    _____

12. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____
13. What are you PRESENT complaints and symptoms?_____

    _____

    _____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

    If yes, please describe: _____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

    If yes, please describe: _____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No

    If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received?

    _____

    _____

    _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

    If yes, please list doctor's name and address:

    _____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. Check symptoms you have notices since the accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Light Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

    Symptoms other than listed above: _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete these questions.

    a. Last Day Worked: _____

    b. Type of Employment: _____

    c. Present Salary: _____

    d. Are you being compensated for time lost from work? ( ) Yes ( ) No

       If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

    If yes, please describe, in detail: _____

    _____

    _____

    _____

23. Other pertinent information: _____

    _____

    _____

    _____

_____ _____

DATE **PATIENT'S SIGNATURE**

Medical Release Authorization

To Whom It May Concern:

I _____ do hereby authorize American Chiropractic and/or American Physical Therapy to release medical records, together with any additional information relative to the diagnosis, treatment, and prognosis of my condition. I also advise the amount of my bills to date as well as the probable amount of the final bill for services rendered to and for me to _____. A photocopy of this authorization shall be considered as effective and valid as the original

_____ _____

Signature Date

Medical Authorization Form

To: Hospital/Doctor:

Please furnish American Chiropractic and/or American Physical Therapy with copies of your records, together with any additional information know to you, relative to the diagnosis, treatment, and prognosis of the patient's condition. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

_____ _____

Signature Date

Please list treating physicians and/or facilities and contact information in regards to your current condition:

_____

_____

_____

_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient:_____

Claim #:_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

American Chiropractic & American Physical Therapy
8417 E. McDowell Rd.
Scottsdale, Arizona 85257

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

American Chiropractic & American Physical Therapy
8417 E. McDowell Rd.
Scottsdale, Arizona 85257

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____

Signature Date

DOCTOR'S LIEN

To: _____
_____
_____

American Chiropractic &
American Physical Therapy
8417 E. McDowell Rd.
Scottsdale, Arizona 85257

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

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

Dated:_____ Patient's Signature: _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Dated:_____ Attorney Signature: _____