ProWellness Chiropractic

PERSONAL INJURY QUESTIONAIRE (MVA) / PERSONAL INFORMATION

Today's Date: _____ Date of Accident: _____

Name: (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

☐ Left-Handed ☐ Right-Handed

Address: _____ City: _____ Zip: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer at Time of Accident: _____ Occupation: _____

Brief Job Description: _____

Employer Address: _____ City: _____ Zip: _____

Dates Employed: From _____ to _____

Have been off work because of this accident? Yes No If Yes, dates from: _____ to _____

Marital Status: (Circle One) Married Divorced Single Spouse's Name: _____

Have you had previous chiropractic care? Yes No If yes, when was your last visit? _____

If you discontinued care, why? _____

How long were you receiving adjustments? _____ How often did you go? _____

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods were used?

_____

PURRPOSE FOR CONTACTING US

List your chief complaint(s) in order of severity:

Pain Intensity Scale: 1 – 10 (1 = least & 10 = greatest)

1. Area of pain: _____ *Frequency:* ○ *Intermittent* ○ *Occasional* ○ *Frequent* ○ *Constant*

Pain Intensity: ○ Minimal ○ Mild ○ Moderate ○ Severe

Pain Start Date: _____

Pain is aggravated by: _____

Pain is relieved by: _____

Pain is better in: ○ AM ○ Mid-day ○ PM ***or***

Pain is worse in: ○ AM ○ Mid-day ○ PM ***or*** ○ Pain *does not change* with the time of day

Pain is: ○ Improving ○ Getting worse ○ Unchanged

Have you had similar symptoms in the past? ○ Yes ○ No

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Have you had similar symptoms in the past? ○ Yes ○ No

Do you have any numbness or tingling in your ○ legs ○ feet ○ toes ○ arms ○ hands ○ fingers?

What is your most COMFORTABLE position? ○ sitting ○ lying on right side ○ lying on left side ○ stomach ○ back ○ standing ○ If other, please describe: _____

Do you have trouble changing positions in bed? ○ Yes ○ No

Does stretching and twisting worsen the pain? ○ Yes ○ No

Do any of the following relieve your pain? ○ heating pad ○ hot bath ○ ice pack ○ hot shower

If you have tried a brace, does it relieve the pain? ○ Yes ○ No

Does a change in shoes or heel height worsen the pain? ○ Yes ○ No

Do you feel better when you are moving around? ○ Yes ○ No

Do your knees ache or hurt? ○ Yes ○ No

Do you have cramps in your: ○ legs ○ arms ○ other? _____

Describe the accident:

_____

_____

_____

_____

Place of the accident (Address): _____

Time Accident Occurred: _____ AM PM

Immediately after the accident, how did you feel?

_____

_____

Were you unconscious? ○ Yes ○ No Were you in a daze: Yes ○ No ○

Did you go to the hospital? ○ Yes ○ No If yes, how were you transported? _____

When did you get to the hospital? ○ Immediately ○ 1-3 hours later ○ 4-12 hours later ○ Days later – how many? ____

Did ambulance attendants place you in: ○ Neck Collar? ○ Splints? ○ Brace?

Name of hospital: _____

Name of doctor you were attended by: _____

Were x-rays taken related to this accident? ○ Yes ○ No

Was a C.T. scan taken? ○ Yes ○ No

List any other lab work or diagnostics related to this accident: _____

Were you admitted to the hospital? ○ Yes ○ No If yes, how long were you there? _____

What treatment was rendered? _____

What recommendations were made? _____

Were you advised to: ○ See your primary physician ○ See orthopedic specialist ○ Go to physical therapy
○ Neurologist ○ Other _____

List any other medical facilities you went to because of the accident (immediate care, primary physician, etc):

_____

List all previous trauma(s) and date(s) or traumas: _____

_____

List any other auto / work accident(s) and date(s) and briefly describe accident, injuries and doctors consulted:

1. _____
2. _____

ProWellness Chiropractic:
A Creating Wellness
Center

Personal Injury Medical Pay

Patient Name_____ Date of Birth_____

Address_____City_____ST___Zip_____

Home phone_____ Cell phone_____

SSN_____

Information Needed

Claim Number:_____ Date of Accident_____

Adjusters Name_____

Address to Send Claims to:_____

City_____ST_____Zip_____

Car Insurance Card (copy) and Policy Number #_____

Patient Signature_____date_____

Clinical Witness_____date_____

ProWellness Chiropractic

11876 Olio Road, Suite 500
Fishers, IN 46037

DOCTOR'S LIEN

TO:_____
_____
_____

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: _____

Please date, sign and return one copy
Reply envelope attached
Keep one copy for your records