LIVE WELL
CHIROPRACTIC

Personal Injury Questionnaire

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____Home phone: _____

Email: _____

Date of Birth:_____ Sex: ◯ Male ◯ Female Marital Status ◯ S ◯M ◯D ◯W

Height: _____ Weight: _____

Date of Accident: _____

How did you hear about our office?

___ Referral (name please_____)

___Internet/Google ___Yellow Pages ___drive by ___Facebook ___ other

Describe what happened in the accident:

_____

_____

_____

_____

1. What was your position in the car?

   Driver: If you were the driver, which hand(s) were on the steering wheel? ◯Right◯Left◯ Both

   Passenger: If you were a passenger, were you sitting in: ◯Front ◯Right Rear ◯Left Rear

2. Did you vehicle strike another vehicle? ◯Yes ◯No
   Was your vehicle struck by another vehicle? ◯Yes ◯No
   Angles of impact: First Collision ◯Front ◯Back ◯Left ◯Right
   Second Collision ◯Front ◯Back ◯Left ◯Right
3. Were you wearing a seat belt? ◯Yes ◯No
   Did you brace for impact? ◯Yes ◯No If yes, did you brace with your ◯Hands ◯Feet
   Which way were you facing at the time of the impact? ◯Straight ahead ◯Left ◯Right
4. Did you strike anything in the vehicle at the time of impact? ◯Yes ◯No
   If yes, specify what part of your body struck what part of vehicle. (Example: head, knee, chin)
   Steering wheel_____ Windshield_____
   Dashboard _____ Roof_____
   Left Side Door_____ Right Side Door_____
   Left Side Window_____ Right Side Window_____
   Other: _____
   Did your seat back break/bend? ◯Yes ◯No
   If you were wearing glasses/sunglasses did they come off of your face? ◯Yes ◯No ◯N/A

5. Immediately following the accident, how did you feel?
   ◯Dizzy/Dazed ◯Disoriented ◯Nervous ◯Nauseous ◯Upset ◯Weak ◯Unconscious
   ◯Other: _____

6. Did you go to the hospital/clinic? ◯Yes ◯No
   If so were you admitted? ◯Yes ◯No If admitted, for how long?_____
   If you went to the hospital, when did you go?
   ◯At the time of the accident ◯Other: _____

   How did you get to the hospital? ◯Drove myself ◯Ambulance ◯Another person

   Name of hospital/clinic:_____

   Name of attending Doctor:_____

7. What treatment was given?
   ◯None ◯Cervical collar ◯X-ray ◯CT scan ◯Stiches
   ◯Medication ◯Physical therapy ◯Instructions for whiplash/sprain/stains
   ◯Instructed to see a private physician ◯Referred to this office
   ◯Other _____

CHIEF COMPLAINTS AND SYMPTOMS:

Neck pain: ◯Yes ◯No ◯Right ◯Left ◯Both

◯Right Shoulder ◯Right arm ◯Right forearm ◯Right wrist

◯Left Shoulder ◯Left arm ◯Left forearm ◯Left wrist

Headache? ◯Yes ◯No Migraine? ◯Yes ◯No

Ringing in ears? ◯Yes ◯No Blurry vision? ◯Yes ◯No

Jaw pain? ◯Yes ◯No ◯Right ◯Left ◯Both sides

Middle back pain? ◯Yes ◯No ◯Right ◯Left ◯Both

Lower back pain? ◯Yes ◯No ◯Right ◯Left ◯Both

Buttock pain? ◯Yes ◯No ◯Right ◯Left ◯Both

◯Right leg ◯Right knee ◯Right ankle ◯Right foot

◯Left leg ◯Left knee ◯Left ankle ◯Left foot

Numbness? ◯Yes ◯No

◯Right shoulder ◯Right arm ◯Right hand ◯ Left shoulder ◯Left arm ◯Left hand

◯Right leg ◯ Right foot ◯Left leg ◯Left foot

Check any which apply to your condition:

◯Dizziness ◯Nervousness ◯Fatigue ◯Anxiety ◯Depression ◯Excessive irritability

◯Fear of Driving ◯Loss of concentration ◯Loss of concentration ◯Jaw clenching

◯Grinding of teeth ◯Nightmares ◯Difficulty Sleeping

Additional symptoms/complaints/injuries:_____

_____

_____

_____

Have you lost any time from work due to your injuries? ◯ Yes ◯No If yes, what dates? _____

Place of employment:_____

Have you had any previous injuries or accidents? ◯Yes ◯No

Describe any accidents: _____

Describe any injuries: _____

Is there any residual pain/permanent paint from previous accidents/injuries? ◯Yes ◯No

How much better did you feel prior to your current condition? (example 100%, 80%, etc.) _____

Show area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

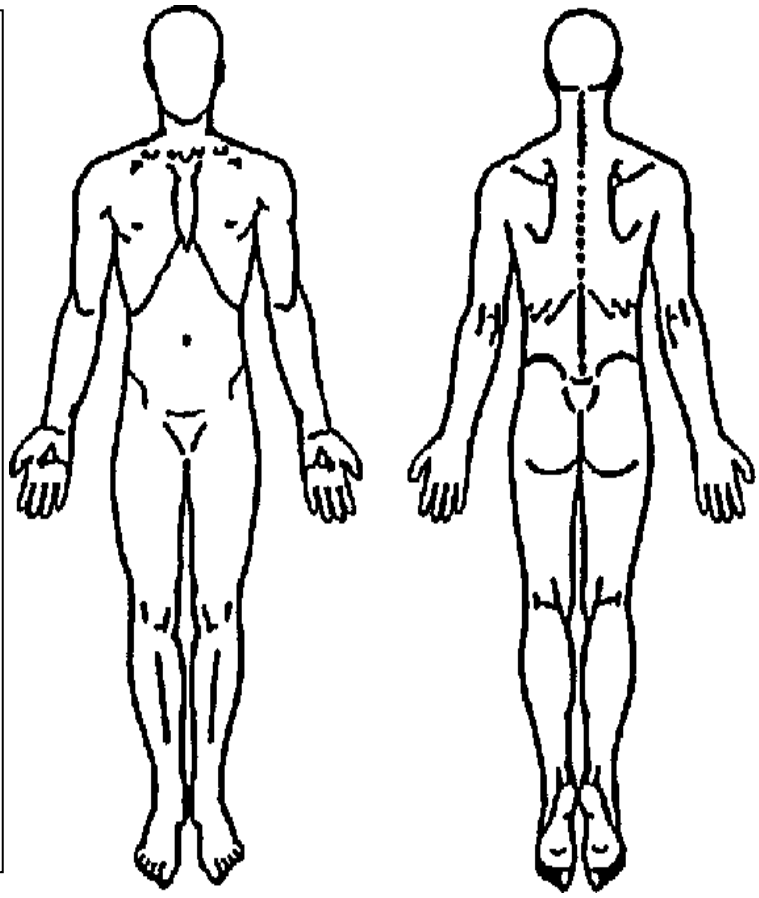
Numbness: ●●●●●●
●●●●●●

Burning: XXXXXXX
XXXXXXX

Aching: *******
****

Stabbing: /////////
/////////

Pins/Needles ○○○○○
○○○○○



TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method of correction is by specific adjustment to the spine.

HEALTH: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. **We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions.** However, if during the course of a chiropractic spinal examination we encounter unusual findings which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom.** Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

AUTHORIZATION FOR CARE

I authorize Live Well Chiropractic and its doctors to administer care as they deem necessary. I authorize the doctors to perform an exam and administer treatment. I clearly understand and agree I am personally responsible for payment of any fees not covered by my insurance.

I, _____ have read and fully understand the above statements.

(printed name)

Signature: _____ Date: _____

(signature of patient or parent/guardian authorizing care for a minor)