ACTIVE CARE CHIROPRACTIC

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Personal Injury Questionnaire

Name _____ Phone # _____
Address _____ City/Prov. _____
Postal Code _____ D.O.B. _____
Alberta Health Care Number _____ Sex _____ Age _____

Employer's Information

Name _____ Phone #_____
Address _____ Postal Code _____

Attorney

Firm _____ Name _____
Address _____ Phone # _____
City _____ Province _____ Postal Code _____

Insurance Company

Name _____ Adjuster _____
Address _____ Phone # _____
City _____ Fax # _____
Province _____ Postal Code _____ Claim # _____

Nature of Accident

Date of Accident _____ Time of Day _____

Were you: [ ] Driver [ ] Passenger [ ] Front Seat [ ] Back Seat

Number of people in your vehicle? _____ Were you wearing your seat belts? [ ] Yes [ ] No

In your own words, please describe the accident, including location, direction headed and speed:

_____

_____

_____

_____

_____

Were you struck from: [ ] Behind [ ] Front [ ] Left Side [ ] Right Side

Were police notified? [ ] Yes [ ] No

Were you knocked unconscious? [ ] Yes [ ] No
If yes, how long? _____

Please describe how you felt:

- BEFORE the accident: _____
- DURING the accident: _____
- IMMEDIATELY AFTER the accident: _____
- LATER THAT DAY: _____
- THE NEXT DAY: _____

Where were you taken after this accident? _____

Did you have X-rays, Cat scan, etc. [ ] Yes [ ] No Where: _____ When; _____

Has another doctor since the accident treated you? [ ] Yes [ ] No

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

_____

_____

What are your PRESENT complaints and symptoms? _____

_____

_____

Since the injury, symptoms: [ ] Improving [ ] Getting Worse [ ] Same

Check Symptoms you have noticed since the accident:

[] Headaches	[] Stiff Neck	[] Ears Ringing	[] Buzzing in Ears	[] Dizziness
[] Heavy Head	[] Tension	[] Fatigue	[] Neck Pain	[]Loss of Balance
[] Light bothering eyes	[] Numbness in fingers	[]Face Flushed	[] Pins and Needles in Arms	[] Fever
[] Loss of Taste	[] Loss of Memory	[] Loss of Smell	[] Sleeping Problems	[] Stomach upset
[] Chest Pain	[] Upset Stomach	[] Cold Sweats	[] Depression	[] Back Pain
[] Shortness of Breath	[] Numbness in toes	[] Irritability	[] Fainting	[] Nervousness
[] Diarrhea	[] Constipation			

Symptoms other than above: _____

_____

_____

_____

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

- Last day of work _____
- Type of employment _____

Are you presently being compensated for time lost from work? [ ] Yes [ ] No. If yes please state type of compensation.

_____

Do you notice any activity restrictions as a result of this injury? [ ] Yes [ ] No If yes please describe in detail:

_____

_____

_____

Any other information we should know? _____

_____

_____

Have you ever been involved in an accident before? [] Yes [] No If yes, please describe, including date(s) and type of accident, as well as injuries received: _____

_____

_____

_____

Did you have any X-rays taken? [] Yes [] No If yes where and when? _____

_____

_____

DATE **Patient's Signature**

Services under the Protocols are billed directly to the insurance company. After that, Section"B" covers a maximum of $750.00. If we receive written Confirmation from the Insurance Adjuster for Direct Billing under Section"B" we will do so. Once this has reached the maximum, the patient is responsible for maintaining the account unless previous arrangements are made. All balances will be subject to a 2% monthly charge.