

Accurate Chiropractic LLC

Personal Injury Questionnaire

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.



Name _____ Sex _____ D.O.B. _____
Marital Status _____ Home Phone _____ S.S. # _____
Address _____ City _____ State _____ Zip _____
Who referred you to us? _____ Occupation _____
(include if child, student, housewife, retired)

Business _____ Company _____
Phone _____ Name _____ Location _____

Spouse's _____ Spouse's _____
First Name _____ S.S. # _____

Spouse's _____
Employer _____ Location _____

Please explain in detail how your injury happened _____

Insurance Co. _____ Policy No. _____ Claim No. _____

Driver of other vehicle(if any)-Name _____
Insurance Co. _____ Claim No. _____

Driver of vehicle in which you were injured(if applicable)-Name _____
Insurance Co. _____ Claim No. _____

Name of your insurance adjuster _____ Phone # _____

Have you retained an attorney? _____

If so, his name and address _____ Phone # _____

You were heading North East South West on _____

Other vehicle was headed North East South West on _____

Were police notified? Yes No (street or highway)

Were you knocked unconscious? Yes No If so, how long? _____

You were struck from Behind Front Left side Right side

You were Driver Passenger Front seat Back seat

Using seat belts Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since the injury are your symptoms Improving? Getting worse? Same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes:

1-never had; 2-previously had; 3-presently have.

MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
 Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIOVASCULAR-RESPIRATORY

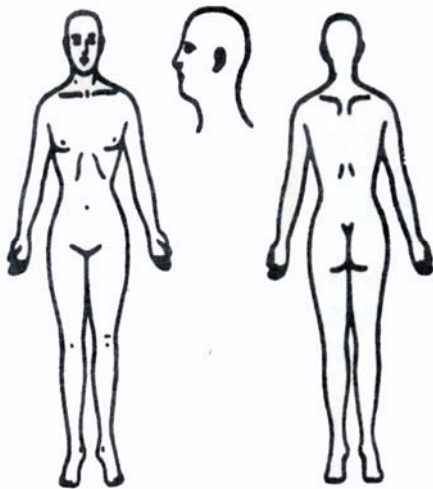
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose Veins

EYE, EAR, NOSE, & THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Difficult breathing through nose
- Sore gums
- Sore throat
- Hoarseness
- Difficult speech

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

Patient accepted? Yes _____ No _____ Doctor's signature _____

**AUTHORIZATION AND REQUEST FOR MEDICAL
RECORDS**

TO: _____

RE: _____

You are hereby requested and authorized to disclose, make available and furnish to **Accurate Chiropractic LLC, 9400 Gladiolus Drive Suite 20 Fort Myers, Fl. 33908**, all information, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment.

Patient / Legal Representative

Date