



Auto Injury Questionnaire

Name: _____ DOB: _____ Age _____ Height: _____ Weight: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Address: _____ E-mail Address: _____

City: _____ State _____ Zip: _____ How did you hear about our office? _____

Marital Status Single Married Separated Divorced Widowed

Occupation: _____ Employer: _____

ATTORNEY INFORMATION:

Do you have an attorney? Yes No

Name: _____ Phone number: _____

INSURANCE INFORMATION:

Personal Injury Insurance Company Name: _____ Claim #: _____

Adjustor's Name: _____ Adjustor's Phone number: _____

Do you have health insurance as a secondary insurance? Yes No

Insurance Name: _____ Member Id: _____

Phone #: _____ Policy Holder Name: _____ DOB: _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Larger Than Life Chiropractic LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.) I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits, I authorize the use of this signature on all insurance claims,, including electronic submissions.

Patient/Responsible Party Signature: _____ Patient/Responsible Party Print: _____

Date: _____

ACCIDENT INFORMATION:

Date of Injury: _____ Where (State/City): _____ Time of Accident: _____ am/pm

Please describe the accident in your own words:

Were you the: Driver Front Seat Passenger (Right) Back Seat LEFT Passenger Back Seat RIGHT Passenger

Were others in the car with you? Yes No

Make & Model of the car you were in? _____ At-fault vehicle: _____

Did the impact to your vehicle come from the: Front Rear Left Side Right Side

What was the approximate speed at the time of the impact? Your vehicle _____ mph Other vehicle _____ mph

What was the weather like at the time of the collision? Dry Wet Icy

Was your vehicle Parked Moving Stopped with brakes applied

At the time of the impact were you: Looking straight ahead Looking to the left Looking to the right Looking down Looking up

Were you braced for the impact (did you see it happening and braced for it)? Yes No

Were you wearing a seat belt? Yes No Did the seat belt break as a result of the impact? Yes No

Did the seat belt have a shoulder harness? Yes No If yes, did it contribute to the pain you are experiencing? Yes No

Do you have any bruises from the seatbelt? Yes No Did the air bag deploy? Yes No

Did your seat have a head restraint (headrest)? Yes No Did your head ride over the headrest? Yes No

Did you hit anything inside the vehicle? Yes No

Check all that apply: Seatbelt Restraint Steering Wheel Dashboard windshield side door side window Other _____

Which part of your body? Chest Head Chin Face R and/or L Knee R and/or L shoulder R and/or L Hand Other _____

Did your vehicle strike the other vehicle or object? Yes No If yes, explain: _____

How much damage was there to the outside of the vehicle? None/ Scratch Moderate A lot Totaled

Estimated damage amount: \$ _____

Did you experience immediate pain? Yes No If yes, Where: _____

Immediately after the accident were you: Conscious Dazed Unconscious

Were the police called to the scene? Yes No If no, why not? _____

Were any tickets issued and to whom? Yes No if yes: _____

Did the ambulance/paramedics arrive at the scene? Yes No If no, why not? _____

Were you taken to the hospital? Yes No Did you drive to the hospital? Yes No

Which hospital? _____ When? _____

Were x-rays taken? Yes No

MRI? Yes No

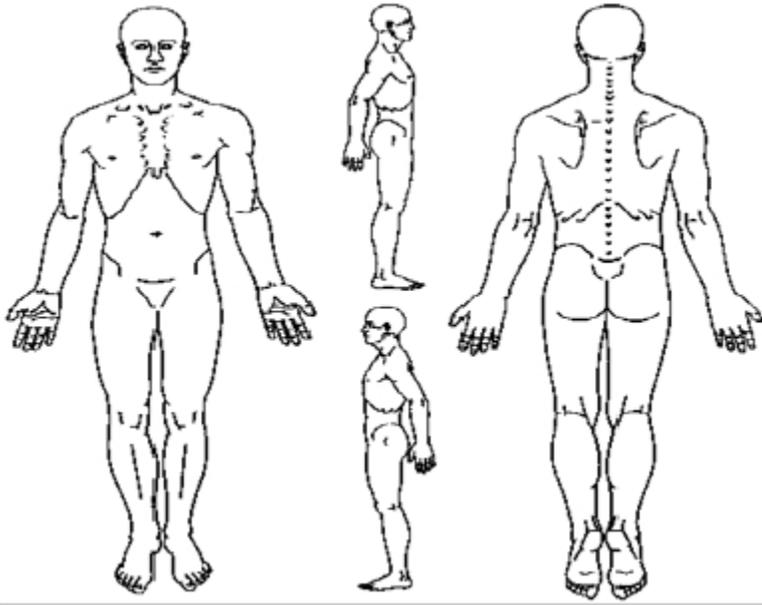
CT? Yes No

Did they prescribe medication? Yes No if yes, what medication? _____

Have you seen any other medical providers for injuries related to this accident? Yes No

If yes, list all providers, their specialty, and treatment dates:

CIRCLE AREAS OF PAIN OR DISCOMFORT FOR ALL COMPLAINT(S):



RATE LEVEL OF DISCOMFORT ON A SCALE OF 1-10 (10 IS THE WORST PAIN)

NECK PAIN: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

SHOULDER/ARM PAIN: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

MID BACK PAIN: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

LOW BACK PAIN: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

HIP/LEG PAIN (RIGHT OR LEFT): None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

HEADACHE PAIN: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

OTHER PAIN: _____ None 0 1 2 3 4 5 6 7 8 9 10 Severe

Percentage of time you feel the discomfort: 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

What does the pain feel like? Achy Burning Crushing Dull Numb Sharp Shooting Stiff Tingling

Does the pain radiate? Yes No. If yes, explain: _____

When did the pain start? _____

Did you have this pain before the accident? Yes No Explain: _____

What makes the pain worse?

Bending Cleaning Cooking coughing dressing driving exercising kneeling lifting lying reaching
 pulling pushing running sitting standing sneezing turning typing walking working Other _____

What makes the pain better? Resting Sitting Stretching Therapy Pain medication Nothing other: _____

My pain is Constant Intermittent Worse in AM Worse in PM

How does the pain affect your life? Lose patience with spouse/children Restricted household duties Hinders ability to exercise
 Restricted in your daily activities Interferes with work Interrupts sleep

What type of work do you do? _____ List job requirements: _____

Have you lost any days of work from this injury? Yes No If yes, give dates: _____

SYMPTOMS: Please check if you have experienced any of the following since this accident.

Tired/Fatigued Difficulty talking Difficulty Sleeping
 Ringing in Ears Dizziness Vomiting
 Unclear Thinking Nausea Changes in Vision
 Difficulty swallowing Difficulty with balance Other: _____

PREVIOUS ACCIDENT HISTORY:

Have you been involved in other vehicle accidents? Yes No Please describe and give dates: _____

When was your last treatment for injuries related to that accident? _____

FAMILY HISTORY:

Is there a family history of any of the following conditions?

Heart Disease _____ Diabetes _____ Cancer: _____ Arthritis: _____

MEDICAL HISTORY:

Please circle if you have currently or have any of the following conditions:

NONE

- | | | | |
|----------------------------------------------------------|-----------------------|---------------------|----------------------|
| ADD/ADHD | CATARACTS | HERPES | PROSTATE PROBLEMS |
| AIDS/HIV | CHEMICAL DEPENDENCY | HIGH CHOLESTEROL | PROSTHESIS |
| ALCOHOLISM | CHICKEN POX | HORMONE PROBLEMS | PSYCHIATRIC CARE |
| ALLERGY SHOTS | COLON TROUBLE | INSOMNIA | RHEUMATOID ARTHRITIS |
| ANEMIA | DIABETES | KIDNEY PROBLEMS | SEXUAL DIFFICULTY |
| ANOREXIA | EAR INFECTIONS | LIVER DISEASE | STROKE |
| APPENDICITIS | EPILEPSY | MEASLES | SUICIDE ATTEMPT |
| ARTHRITIS | GALL BLADDER PROBLEMS | MENOPAUSAL PROBLEMS | THYROID PROBLEMS |
| ASTHMA | GLAUCOMA | MIGRAINES | TMJ PAIN |
| BLEEDING DISORDER | GOUT | MISCARRIAGE | TONSILLITIS |
| BLOOD PRESSUE
(HIGH OR LOW-CIRCLE) <i>ALTA o BAJA</i> | HEART ATTACK | MULTIPLE SCLEROSIS | TREMORS |
| BREAST LUMP | HEART PROBLEMS | MUMPS | TUBERCULOSIS |
| BROKEN BONES | HEMORRHOIDS | OSTEOPOROSIS | TUMORS/GROWTHS |
| BRONCHITIS | HEPATITIS | PACEMAKER | TYPHOID FEVER |
| BULIMIA | HERNIA | PARKINSON'S DISEASE | ULCERS |
| CANCER | HERNIATED DISC | PNEUMONIA | VENERAL DISEASE |
| | | POLIO | OTHER _____ |

Social History:

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ pack(s) day

Exercise:

Frequently Moderately Occasionally None

Allergies:

Circle any known allergy you have:

- | | | | |
|-------------|--------------|---------------|--------------|
| NONE | | | |
| MILK | SOY | PHENYTOIN | DOG DANDER |
| EGGS | WHEAT | CARBAMAZEPINE | CAT DANDER |
| PEANUTS | GLUTEN | MOLD | LATEX |
| ALMONDS | PENICILLIN | DUST | OTHER: _____ |
| CASHEW | SULFA DRUGS | FUNGUS | |
| WALNUTS | TETRACYCLINE | MITES | |
| FISH | CODEINE | TREE POLLEN | |
| SHELLFISH | NSAIDS | WEED POLLEN | |

Are you currently under medical care for any condition? Yes No

Explain: _____

Please list any and all medications you are currently taking: _____

Please list any surgeries and/or hospitalization you have had (type & date): _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health, I will give complete and accurate information during my exam.

Print Name: _____

Signature: _____ Date: _____

X-ray Questionnaire: FOR WOMEN ONLY –

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- There is a possibility that I may be pregnant at this time
- Yes, I am definitely pregnant
- No, I am definitely not pregnant at this time
- I request that x-ray films not be taken because

Date of last menstrual period: _____

Patient Signature: _____ Date: _____