

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Employer's Name _____ Employer's Address _____
Your Ins. Co. _____ Policy # _____ Agent's Name _____
Name on Policy (if other than self) _____ Policy # _____
Responsible Party's Name _____
Address _____ City _____ State _____ Zip _____
Policy Holders Name _____ Policy # _____

ATTORNEY:

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Were there any Witnesses? Yes No Names _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Accident _____
2. Were you: Driver Passenger Front Seat Back Seat
Does your Car have Headrests? Yes No If yes, what height was it at time of impact:
 Bottom of neck Bottom of head Middle of neck
3. Number of People in Vehicle _____ Were you wearing seat belts? _____
4. What direction were you headed? North East South West
5. What direction was the other vehicle headed? North East South West
6. Were you struck from: Behind Front Left side Right Side
7. Approximate speed of your car? _____ mph Other Car _____ mph
8. Were you knocked unconscious? Yes No If yes, how long? _____
9. Were police notified? Yes No
10. In your own words, Please describe accident:

11. Did you have any physical complaints BEFORE THE ACCIDENT? Yes No If yes, please describe detail: _____

12 Please describe how you felt:

- a. DURING the accident: _____
- b. IMMEDIATELY AFTER the accident: _____
- c. LATER THAT DAY: _____
- d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

14. Do you have any congenital(from birth) factors which relate to this problem? Yes No If yes, please descr _____

15. Do you have any previous illnesses which relate to this case? Yes No If yes, please describe: _____

16. Have you ever been involved in an accident before? Yes No If yes, please describe, including dates types of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? Yes No If yes, please list doctor's name address: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms: Improving Getting worse Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--------------------------------------|--|---|--|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Hands seem too heavy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Pins/needles in Arms | <input type="checkbox"/> Light bothers eye | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Pins/needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other |

Symptoms Other than above _____

21. Have you lost time from work as a result of this accident? Yes No If yes please complete this question.

a. Last day worked: _____

b. Type of employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from your work? Yes No If yes please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? Yes No If yes, Please describe: _____

23. Other pertinent information: _____

Date

Patients Signature

OUCH

Accidents
Aches
Allergies
Bumps
Colds
Constipation
Falls
Fatigue
Headaches
Indigestion
Nervousness
Pains
Sleeplessness
Stiffness
Stomach
trouble
Tension

CHANGE OF CONDITION REPORT

If you have experienced a sudden change in your physical condition, we would like to know about it because we want your care to be the best possible for your present state. Your complete recounting of any discomfort you have felt, and any accidents or injuries you have had recently, even if you experienced no apparent reaction, will help us help you more. Please provide us with the information requested below.

Name: _____ Date: _____

List any falls, accidents, over exertions, or other injuries you have had since your last visit: _____

Date of Injury: _____ Time: _____

Where did it happen? _____

What happened? _____

Check Symptoms You Have Noticed:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head seems to heavy | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of taste | _____ |

List any out-of-ordinary pains, discomforts, or other symptoms you have experienced as a result of this injury:

What have you done to try to relieve your symptoms?

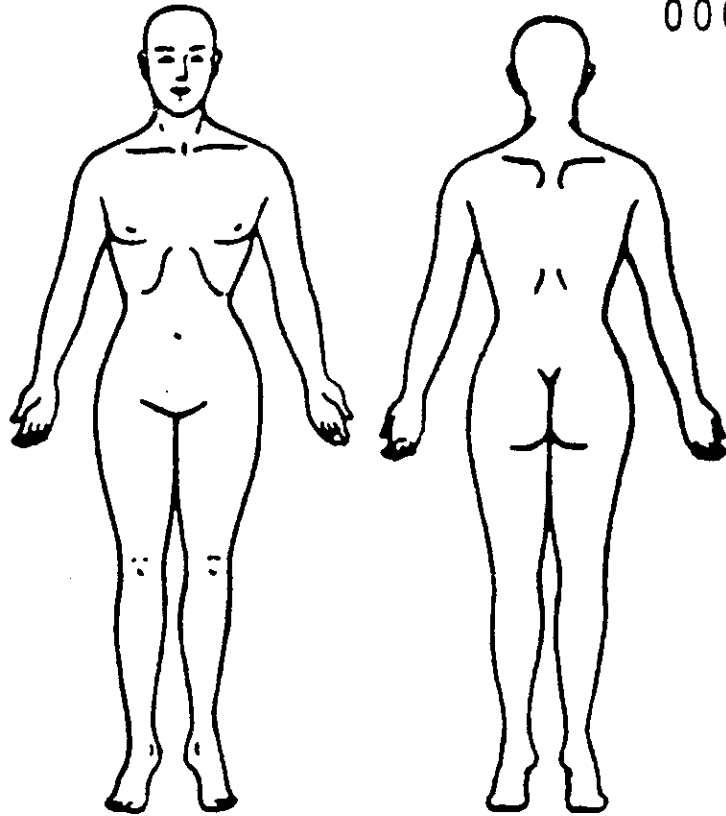
Have you received any other medical care for this injury?

If so, where and what?

ALSO COMPLETE OTHER SIDE!

Please put the appropriate symbol at the area of your problem.

- === Dull pain
- xxx Sharp pain
- +++ Burning
- ooo Numbness/tingling



Descriptions:

PERSONAL HEALTH HISTORY

WELCOME TO OUR FAMILY!

Date _____

Name _____

Address _____ City/State/Zip _____

Home phone _____ Work phone _____

Cell Phone _____ Email Address _____

Date of birth _____ Social Security # _____

Marital Status: S M D W O Spouse's name _____ Age _____

Children's name/age _____

Name of employer _____ Occupation _____

Referred by _____ Hobbies _____

Name of previous chiropractors _____

When was your last visit? _____ How long were you receiving chiropractic adjustments? _____

Reason for coming in _____

INJURIES:

What accidents have you had (ex: bicycle, car, motorcycle, sports, slips/falls) at work or at home?

Include dates. _____

Were you ever knocked unconscious? YES NO

What fractures or broken bones have you had? Include dates. _____

SURGERY:

What major surgery have you had? Include dates. _____

What minor surgery have you had? (Tonsillectomy, appendectomy, wart/cyst removal, dental extraction.)

MEDICATION:

Present prescription drugs

Past prescription drugs

Over-the counter drugs
(aspirin, cold tablets, cough syrup,
laxatives, etc)

THERAPY

Are you presently under any therapeutic care? _____ What type? _____
What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc?) Include dates. _____

BIRTH RECORD

Type of birth (vaginal, Cesarean, forceps, etc.) _____ Complications during your mothers pregnancy or during your birth? _____
Complications after your birth? _____

CURRENT HEALTH

How would you describe your current health? _____
How would you describe your family's health? _____
Describe your: Vision _____ Hearing _____ Coordination _____
Do you use any of the following: TOBACCO ALCOHOL COFFEE/TEA COLA MILK
Level of stress in your life: MILD MODERATE EXTREME Rating of stress: 1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following:
_____ Bottled drinking water _____ Vitamins _____ Health food products (organic products, etc.)

FINANCIAL INFORMATION

Who is responsible for this account? SELF SPOUSE OTHER Name if other _____
What method of payment will you be using? INSURANCE CASH CHECK CREDIT CARD OTHER
Name of insurance company _____ Name of insured _____
Date of birth of insured _____ Policy number _____

Please check any of the following that give you difficulty or you have had recently

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Numb legs/feet |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Menstrual cramps/pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Nerves/nervousness | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Shoulder/arm tightness | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Shoulder/arm pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Facial twitch | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Pins & needles in hands | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pain in legs/feet |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaw pain/TMJ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Ear ache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | |

TERMS OF ACCEPTANCE

If a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A 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 to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of Ferguson Family Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____
signature of parent or guardian if minor

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Ferguson Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to FFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If FFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to FFC to use my name on a welcome board, referral board, and birthday board.
- I give permission to FFC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give FFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Ferguson Family Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____

My name (please print): _____

My Signature: _____

Today's Date: _____

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print): _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act on Patient's Behalf: _____
