Name: _____ File: _____

CROSSROADS FAMILY CHIROPRACTIC

Personal Injury Questionnaire

(PLEASE PRINT CLEARLY) Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security #: _____- _____-_____ Birth Date: _____/_____/_____ Age:_____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

Employer:

☐ Not working, or Company: _____

Occupation: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Accident/Injury Information:

Please indicate the type of accident in which you were involved:

☐ auto ☐ work ☐ fall ☐ other: _____

Date of Accident: _____ Time: _____ ☐ am/ ☐ pm Location: _____

In your own words, please describe the accident/injury: _____

_____

_____

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10789 Bradford Road, Suite 110 Littleton, CO 80127
Telephone: 303-904-8641 Fax: 303-904-8793

Name: _____ File: _____

SECTION 1

1. MEDICAL INSURANCE INFORMATION

Check here if no insurance ☐

Insurance Company Name: _____ Phone: _____

ID #: _____ Group #: _____

If subscriber is other than the patient:

Subscriber's Name: _____ Date of Birth: _____

2. ATTORNEY INFORMATION

Check here if no attorney retained ☐

Law Firm Name: _____ Phone: _____

Attorney's Name: _____

SECTION 2

2. CAR INSURANCE OF CAR YOU WERE IN DURING THE ACCIDENT

IMPORTANT: This section must be completed in full or our office will not be able to complete billing for your claims. If we are unable to obtain this information, you will be financially responsible for your treatment.

Policy Holder Name: _____ Address: _____

Insurance Company: _____ Address: _____

Policy #: _____ Claim #: _____

Adjuster: _____ Phone #: _____

Make/Model of Car: _____

Has this insurance company been notified? ☐ Yes ☐ No Is there "Med-Pay" on this policy? ☐ Yes ☐ No

Have you spoken to someone at your insurance company regarding this claim? ☐ Yes ☐ No

3. CAR INSURANCE OF YOUR OWN CAR, IF DIFFERENT THAN WHAT IS LISTED IN SECTION 2

Policy Holder Name: _____ Address: _____

Insurance Company: _____ Address: _____

Policy #: _____ Claim #: _____

Adjuster: _____ Phone #: _____

Make/Model of Car: _____

Has this insurance company been notified? ☐ Yes ☐ No Is there "Med-Pay" on this policy? ☐ Yes ☐ No

Name: _____ File: _____

4. CAR INSURANCE OF THE OTHER PARTY THAT WAS INVOLVED IN THE ACCIDENT

Policy Holder Name: _____ Address: _____

Insurance Company: _____ Address: _____

Policy #: _____ Claim #: _____

Adjuster: _____ Phone #: _____

Make/Model of Car: _____

Has this insurance company been notified? ☐ Yes ☐ No Driver's Name _____

SECTION 3

5. NATURE OF ACCIDENT

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Was anyone issued a citation for this accident? ☐ Yes ☐ No If yes, who? _____

If you were not the driver, driver's name: _____

Number of people in your vehicle: _____ Were you wearing seatbelts/helmets? _____

Did an airbag deploy? If yes, which one(s)? _____

Which direction were you traveling? ☐ North ☐ South ☐ East ☐ West

On (name of street): _____

Which direction was the other vehicle traveling? ☐ North ☐ South ☐ East ☐ West

On (name of street): _____

Impact to your vehicle was on: ☐ Rear ☐ Front ☐ Left Side ☐ Right Side

Approximate speed of your car: _____ mph

Approximate speed of other car: _____mph

The accident was: ☐ Single car crash ☐ Two vehicle crash ☐ More than 2 vehicles ☐ Head-on crash

☐ Side crash ☐ Rollover ☐ Rear-end crash ☐ Hit guard rail/tree ☐ Ran off road

Name: _____ File: _____

During and after the crash, your vehicle:

☐ kept going straight, not hitting anything
☐ kept going straight, hitting car in front
☐ kept going straight, hitting object other than car
☐ was hit by another vehicle
☐ spun around, not hitting anything
☐ spun around, hitting another car
☐ spun around, hitting object other than car

Answer the following questions only if you were hit from behind.

A. Does your vehicle have:

☐ Moveable head restraints ☐ Fixed, non-moveable head restraints ☐ No head restraints

B. Please indicate how your head restraint was positioned at the time of the crash

☐ At the top of the back of your head.
☐ Midway height of the back of your head.
☐ Lower height of the back of your head
☐ Level with your neck
☐ Level with your should blades (upper back), below neck

C. Estimate the distance between the back of your head and the front of the head restraint.

_____ inches.

Answer the following questions only if your vehicle was hit in the front or side.

A. Did any of the front or side structures, such as the side door dash board, or floorboard of your car dent inward during the crash? ☐ Yes ☐ No

B. Did the side door touch your body during the crash? ☐ Yes ☐ No

C. Did your body slide under the seatbelt? ☐ Yes ☐ No

D. Was the door(s) of your vehicle damaged to the point where the door(s) could not be opened? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No **If yes, for how long?** _____

Please indicate if your body hit something or was hit by any of the following:

Head: _____
Face: _____
Shoulder: _____
Neck: _____
Chest: _____
Hip: _____
Knee: _____
Foot: _____

A. Windshield
B. Steering Wheel
C. Side door
D. Dashboard
E. Car frame
F. Another occupant
G. Seat
H. Seatbelt

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SECTION 4

6. INJURY INFORMATION

Did you have any physical complaints before the accident? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

_____

Describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

What are your present complaints/symptoms? _____

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, please list who you have seen and what treatment was rendered? _____

_____

_____

Since the accident, are your symptoms: ☐ Improving ☐ Worsening ☐ Remaining the same

Check symptoms that you have noticed since the accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiffness	☐ Dizziness	☐ Fatigue	☐ Loss of balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles – Arms	☐ Light Bothers Eyes	☐ Loss of Smell	☐ Cold sweats
☐ Nervousness	☐ Pins & Needles – Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ringing in Ears	☐ Diarrhea	☐ Other (list

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below)

Have you noticed any activity restrictions as a result of the accident? ☐ Yes ☐ No If yes, please describe in detail: _____

_____

Have you lost time from work/school as a result of this accident? ☐ Yes ☐ No

If yes, last day worked: _____

Total number of days missed to this point: _____

If you did not see a doctor within the first week following the accident, indicate why: _____

_____

If you did not see a doctor within a month of the accident, indicate why: _____

_____

Have you ever been involved in an accident prior to this accident? ☐ Yes ☐ No If yes, please describe, including date(s), type(s) of accident, injury(ies): _____

_____

_____

Do you have any previous illness that relates to this case? ☐ Yes ☐ No

If yes, please describe _____

_____

Do you have any congenital (from birth) factors that relate to this problem? ☐ Yes ☐ No

If yes, please describe _____

_____

Other pertinent information: _____

_____

_____

_____

Please complete the following page.

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Read each of the following statements and initial.

I understand that I am directly and fully responsible for all medical bills for services rendered to me. ___

I understand that this office requires Med Pay benefits to be used first if such benefits are available. ____

I understand that if it is necessary for the treating provider to wait for payment, a lien may be filed with the county and/or my attorney. ____

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize payment to be made directly to the treating provider or clinic under which the services are billed. ____

For automobile claims, I direct Med Pay benefits to be paid directly to the treating provider or clinic. I understand that payment for Third Party claims will usually be paid directly to me. I further understand it is then my obligation to forward payment to the treating provider or clinic. ____

_____ _____

Signature of patient, or responsible party for minor Date

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