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: _____

_____

_____

Crossroads Family Chiropractic
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

3. WORKER'S COMPENSATION INFORMATION

Employer at time of accident/injury: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer's Insurance Carrier _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Claim #: _____

Agent/Adjuster _____ Phone: _____

Has this insurance company been notified? ☐ Yes ☐ No

****For a fall or other accident, complete Section 3, then proceed to Section 4.****

SECTION 3

4. LIABILITY INSURANCE INFORMATION

Responsible party name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ File: _____

Insurance Carrier: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Claim #: _____

Agent/Adjuster _____ Phone: _____

Has this insurance company been notified? ☐ Yes ☐ No

SECTION 4

5. 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

Name: _____ File: _____

☐ 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 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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Name: _____ File: _____

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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