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Chiropractic Physician
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Boston, MA 02215

Personal Injury Questionnaire

Dear Patient: This information will be considered confidential. We need this information to help determine how best to help you, and to fill out the necessary insurance forms. Please take the time to complete this form as accurately as possible. Thank you.

Today's Date _______________

Name_________________________ Sex: Male / Female

Address__________________________ City, State, Zip________________________________

Home or Mobile no. (____)___________ Work Tel. No.______________________

Soc. Sec. no.______-_____-______ Birth date *(mm/dd/yyyy)* ________/_____/________

Employer_________________________ Occupation _____________________

Marital Status_________________ Number of children and ages _________________

1) Date and time of accident:___/___/_____, at ______A.M./ P.M. Location:___________________

2) **Type of accident:**
Driving a car_____ a passenger in a car_____ Pedestrian_____ On a bicycle______ Slip and fall_____

3) Please explain how the accident happened: ____
____
____

4) Please list areas of pain/injury: ____

5) When did symptoms first appear?____

6) Where did you go immediately after the accident? □ Home □ Emergency department □ Other

If you went to an emergency department, please give the name and address of hospital:
____ Taken by ambulance? □ yes □ no

Were x-rays taken? □ no □ yes; what area(s) of body___________________________

Was medication prescribed? □ no □ yes; drug name(s)? _____________________________

Were any recommendations made to you?____

***If a motor vehicle accident**: How many people were in your vehicle? _________
Was your head turned when the accident happened?__________
Please check one: I braced myself for the accident_____ The accident was a total surprise_____
Were you wearing a seat belt? y / n Which seat were you in? ________________
What size car hit you? compact / small / midsized / large / SUV or light truck / large truck or bus
What size was your car? compact / small / midsized / large / SUV or light truck / large truck or bus
How fast was your car traveling? _______mph How fast was the other car traveling? _______mph
What happened to your body during the accident? thrown forward and backward / thrown side to side / thrown over seat / pinned in vehicle / cut or bruised: ________________
Did you hit your head / shoulder / knee / other: _____________? on what part of the car?______________
What was the dollar amount to repair your car? $___________

Have you seen any other doctors or therapists for this condition? □ yes □ no
If so, please fill out below:
1) name and address of doctor/therapist:____
date(s) seen:________________ Were x-rays taken?______________
What treatment was provided? ____

2) name and address of doctor/therapist:____
date(s) seen:________________ Were x-rays taken?______________
What treatment was provided? ____

Did you miss any time at work because of this injury? □ no □ yes; dates:______________________

Please describe any previous accidents or injuries (include motor vehicle accidents, falls, etc.):
1.____
2.____
3.____
4.____
5.____
6.____

Please describe in detail your physical work activities (e.g. long hours of sitting, light or heavy lifting, etc.) ____
____
____

Motor Vehicle Information:

1) Are you the owner of the vehicle you were driving? □ yes □ no
If not, please give the name and address of the owner:
____
Your relationship to the owner:____

2) Insurance company of vehicle you were traveling in: ______________________________
Policy #______________________ Claim #____________________________

3) Insurance company of other vehicle in accident:____

Owner’s name and address:____

4) Are you covered by any type of health insurance? □ yes □ no

If so, please list insurance company name and policy # (please provide card at the front desk):
____

5) Have you retained an attorney? □ yes □ no

If so, please give name and phone number:
____

••• *Please read, sign and date to indicate your understanding of the paragraphs below:*

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance companies. However, I clearly understand and agree that all services rendered to me are charged to me, and that ultimately I am personally responsible for payment. I understand also that I may be billed a fee for any missed appointments, as well as for cancellations less than 12 hours in advance of the appointment time.

I authorize the above named insurance company to pay Dr. Stein directly for all charged for and related to service rendered to me. I understand any deductible, co-payment amount, or balance not paid by insurance will be my responsibility to pay to Dr. Stein. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

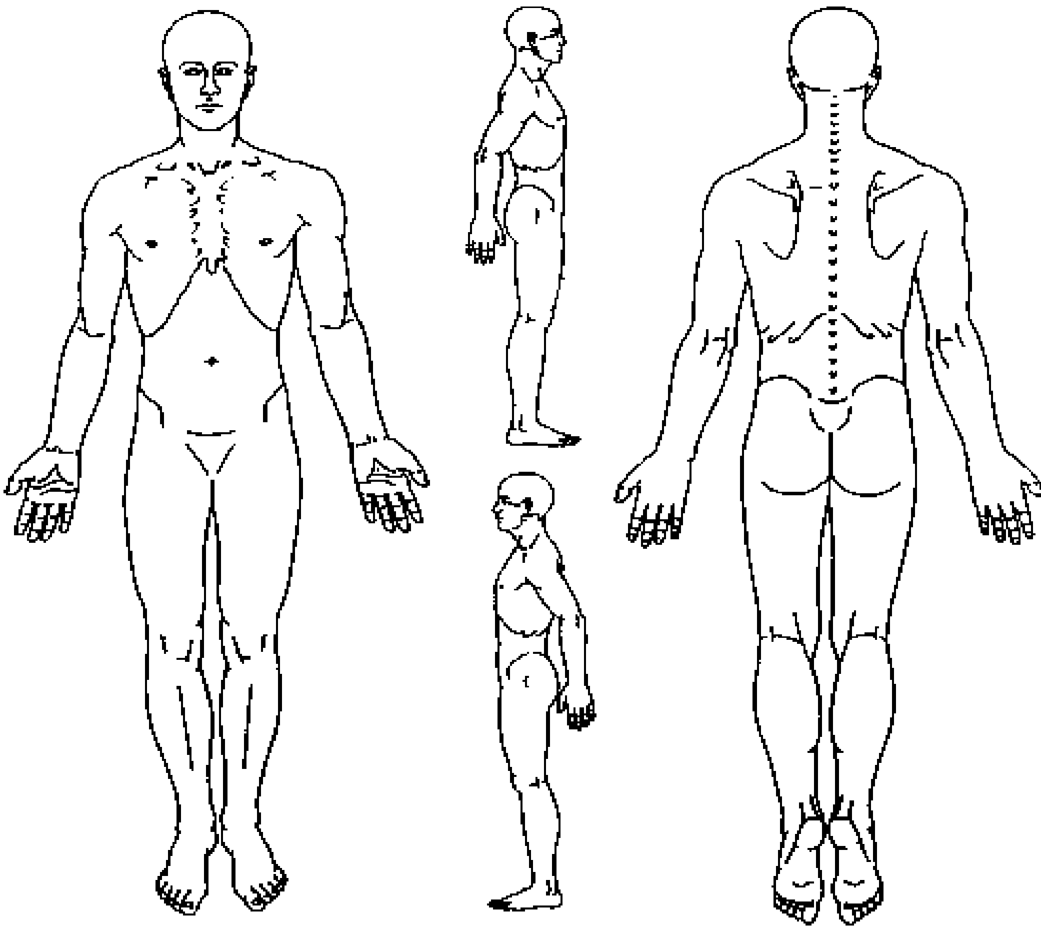
I understand that, in accordance with Massachusetts Automotive Insurance Company Policy, I am required to file a Personal Injury Protection form with my automotive insurance company. I understand failure to file a “PIP” form may result in a denial of my accident claim.

Patient signature_______________________________ Date _________________

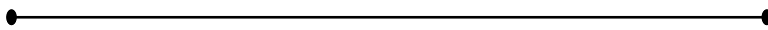
Name ________________________ ☐ *Initial* ☐ *Re-evaluation*

Please indicate areas where you experience pain, using the body outlines below. Please mark the quality of the pain, using the suggested code letters, or other indicators you prefer.

A = ache
B = burning
N = numbness
P = pins and needles
S = sharp/stabbing
X= other



Please mark your level of pain anywhere on the line below:



no pain — worst possible pain

HEALTH HISTORY

PATIENT NAME________________________________ BIRTHDATE____/____/____

This history form provides us with information to help us meet all your healthcare needs. **This is a confidential part of your medical record.**

Today's date________________________________
Place of Birth______________________________
Highest level in school_______________________
Occupation_________________________________
Previous occupations________________________
Marital status______________________________
Hobbies___________________________________
Exercise/recreation_________________________
Smoking (type & amount per day)______________
If former smoker, date quit__________________
Alcohol (type & amount per week)______________
Caffeine (type & amount per day)______________
Recreational drugs (type & amount per day)___________
Usual weight________My ideal weight___________
Date of last dental exam_____________________
Please list all allergies (foods, drugs, environment)______________________________________
____
____ When was your last physical exam?______________
Primary doctor:_______________Phone__________
address:___________________________________

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:
____
____
____
____
____

Please list all medicines you are currently taking (include nonprescription drugs):
____
____
____
____

Describe all serious accidents, severe injuries, head injury, fractures/broken bones (include date occurred):
____
____
____

Any history of family/partner violence?_______________

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
____
____

PAST MEDICAL HISTORY

Do you have, or have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Condition		
measles	no	yes
mumps	no	yes
chickenpox	no	yes
whooping cough	no	yes
diphtheria	no	yes
pneumonia	no	yes
rheumatic fever	no	yes
heart disease	no	yes
arthritis	no	yes
sexually transmitted disease	no	yes
anemia	no	yes
bladder infection	no	yes
epilepsy	no	yes
migraine headaches	no	yes
tuberculosis	no	yes
diabetes	no	yes
cancer	no	yes
polio	no	yes
glaucoma	no	yes
hernia	no	yes
blood or plasma transfusions	no	yes
back trouble	no	yes
high/low blood pressure	no	yes
asthma	no	yes
hives/eczema	no	yes
AIDS or HIV+	no	yes
infectious mono	no	yes
bronchitis	no	yes
multiple sclerosis	no	yes
mitral valve prolapse	no	yes
stroke	no	yes
high cholesterol	no	yes
hepatitis	no	yes
ulcer	no	yes
kidney disease	no	yes
thyroid disease	no	yes
bleeding tendency	no	yes
depression	no	yes

Any other disease/disorder? (please list):_______________

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

• I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

______________________________ **_OR_** ______________________________

printed name *authorized personal representative*

______________________________ ______________________________

signature *date*

____

date