WOMACK CHIROPRACTIC CENTER, P.A.
1430 Palm Bay Rd. NE, Suite C
Palm Bay, FL 32905
(321)723-2113 Fax(321)952-0848

PERSONAL INJURY QUESTIONNAIRE

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Male____ Female ____ SS# _____

Marital Status (circle one): Married Single Divorced Widow Spouse/Partner Name _____

Work Phone _____ Employer Name _____

Person to contact in an emergency _____ Phone _____

EMAIL Address: _____ Are you a Full Time Student? ( ) Yes ( ) No

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ White
□ Native Hawaiian or Other Pacific Islander □ Declined □ Unknown/Unavailable

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined □ Unknown/Unavailable

Primary Language: □ Arabic □ Chinese □ English □ French □ German □ Greek □ Hebrew □ Italian
□ Japanese □ Korean □ Spanish □ Vietnamese □ Declined □ Unknown/Unavailable

Date of most recent: Annual Physical _____ Spinal X-rays _____ Spinal MRI/CT SCAN _____

Current Medications: _____

Medications you are allergic to: _____

Have you ever smoked cigars or cigarettes?_____ Do you currently smoke? _____ If so, packs per: Day___ Week___

Do you drink alcohol? _____ If so, how many drinks per: Day _____ Week _____

Height _____Weight _____ **For Women Only**: Most Recent Menstrual Cycle _____Are you pregnant: ( ) Yes ( ) No

AUTO INSURANCE
Auto Insurance _____ Claim# _____

Policyholder's Name _____ Policy # _____

Relationship to policyholder _____ Policyholder's Date of Birth _____

HEALTH INSURANCE
Health Insurance _____ Policy # _____

Policyholder's Name _____ Policyholder's Date of Birth _____

Policyholder's Employer _____ Policyholder's SS# _____

Relationship to Policyholder _____

For office use only
Blood Pressure _____/_____ Pulse _____ Respirations _____

ATTORNEY
Name _____ Phone _____

NATURE OF ACCIDENT

Date of Accident_____ Time of Day _____AM/PM Were police notified? ( ) Yes ( ) No

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Did you sense or see the accident coming? ( ) Yes ( ) No

Number of people in your vehicle? _____ Were you wearing seatbelts? ( )Yes ( )No

What direction were you headed? ( ) North ( ) East ( ) South ( ) West

On (name of street) _____City _____State_____

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

Approximate speed of your car: _____mph Other car: _____mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____

Name of Hospital/Facility you went to after the accident?_____ Did you receive treatment for your injuries? ( ) Yes ( ) No
Describe treatment _____
_____
Are you still receiving treatment at that facility or any other? _____

Did you have any XRAYS/MRI/CT Scans following the accident? _____

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

Did you have any physical complaints BEFORE THE ACCIDENT: ( )Yes ( )No If yes, please describe in detail:_____
_____

Please describe how you felt:

DURING the accident: _____ LATER THAT DAY: _____
THE NEXT DAY: _____

IMMEDIATELY FOLLOWING the accident how did you feel? (select one or more)
□ Disoriented or Dizzy □ Nausea □ Tightness in your chest □ Unconscious □ Other - Please describe:
_____

What are your PRESENT complaints and symptoms? _____
_____

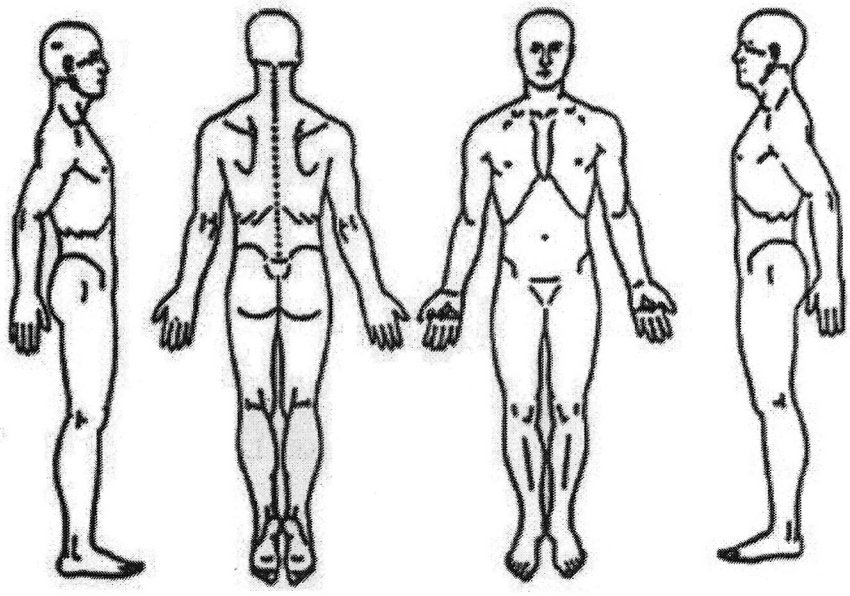
Frequency of symptoms: ___Constant ___75% of the time ___ 50% of the time ___25% of the time ___ Rare

Nature of your symptoms? ___ Sharp ___ Dull ache ___ Numb ___ Shooting ___ Burning ___ Tingling Other _____

Which phrase best describes ***changes*** in your symptoms throughout the day: ____Worse in morning
_____ Worse in afternoon _____ Worse at night ___ Changes with weather ___ Does not change

Do you have increased symptoms after any of the following activities, if so after how long?
Sitting ____ minutes Standing ____ minutes Walking ____ minutes Other _____

Indicate where your symptoms are located, and rate from 0 - 10:



0 1 2 3 4 5 6 7 8 9 10
None Unbearable

Does anything help relieve your symptoms? Ice Heat Stretches Rest Medications _____ Other _____

Please briefly list any general health issues you have _____

Do you have a family history of neck or back problems, if so please describe:_____
Father _____ Mother _____ Brother _____ Sister _____

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

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

Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name:

_____ What type of treatment did you receive?_____

Primary Care Physician Name _____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

□ Headache	□ Irritability	□ Numbness in Toes	□ Face Flushed	□ Feet Cold
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Buzzing in Ears	□ Hands Cold
□ Neck Stiff	□ Dizziness	□ Loss of Balance	□ Stomach Upset	□ Fainting
□ Fatigue	□ Tension	□ Head Seems to Heavy	□ Constipation	□ Depression
□ Back Pain	□ Ears Ringing	□ Pins & Needles in Arms	□ Lights Bother Eyes	□ Loss of Taste
□ Fever	□ Sleeping Problem	□ Numbness in Fingers	□ Loss of Smell	□ Diarrhea
□ Nervousness	□ Cold Sweats	□ Pins & Needles in Legs	□ Loss of Memory	□ _____

What activities are limited by your discomfort: (select one or more)

□ Bending	□ Bowel Movements	□ Coughing	□ Daily Routine	□ Driving	□ Getting Up
□ Lifting	□ Lying Down	□ Pulling	□ Pushing	□ Reading	□ Sitting
□ Sleeping	□ Sneezing	□ Standing	□ Urination	□ Turning my head	
□ Walking	□ Working	□ Other _____			

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:

Last date worked: _____ Type of Employment: _____ Present Salary: _____

Are you being compensated for time lost from work? ( ) Yes ( ) No

Are you covered by _____Medicare or _____Medicaid?

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Womack Chiropractic Center, P.A. will prepare any necessary reports and forms to assist me in making collection from the insurance co. and that any amount authorized to be paid directly to Womack Chiropractic Center, P.A. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ _____

Patient, Parent, Guardian or Patient's Legal Representative Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people of whom you authorize the Practice to release PHI.

_____ _____

_____ _____

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