Stevens Creek Chiropractic
Personal Injury Questionnaire

Name:_____Date:_____
Address:_____City:_____
State:_____Zip:_____Phone 1:_____Phone 2:_____
Email:_____Date of Birth:_____
Occupation:_____Employer:_____Referred By:_____
Marital Status: S M D W Spouse Name:_____Children? Y N #_____

ACCIDENT INFORMATION

Date of Injury/Accident: _____Time of Incident: _____
How many people were in the vehicle? _____Where were you sitting? _____
Did you have your seat belt on? Y/N Did your air bag deploy? Y/N
Where did it happen? _____What direction? _____
What speed were you going? _____ What speed was the other car going?_____
Do you have an Attorney? Y/N Name: _____ Phone: _____
Please describe your accident in further detail: _____
_____
_____
_____

HEALTH HISTORY: Please Explain Any/All **Yes** Answers:

Age:_____ Height:_____ Weight:_____

Drugs, Prescription, OTC?	**Y N**	_____
Surgeries? Hospitalizations?	**Y N**	_____
Injuries During Sports?	**Y N**	_____
Auto Accidents?	**Y N**	_____
Other Old Traumas?	**Y N**	_____
Did You Ever Break Any Bones?	**Y N**	_____
Diseases/Disabilities?	**Y N**	_____
Significant Family Medical History?	**Y N**	_____

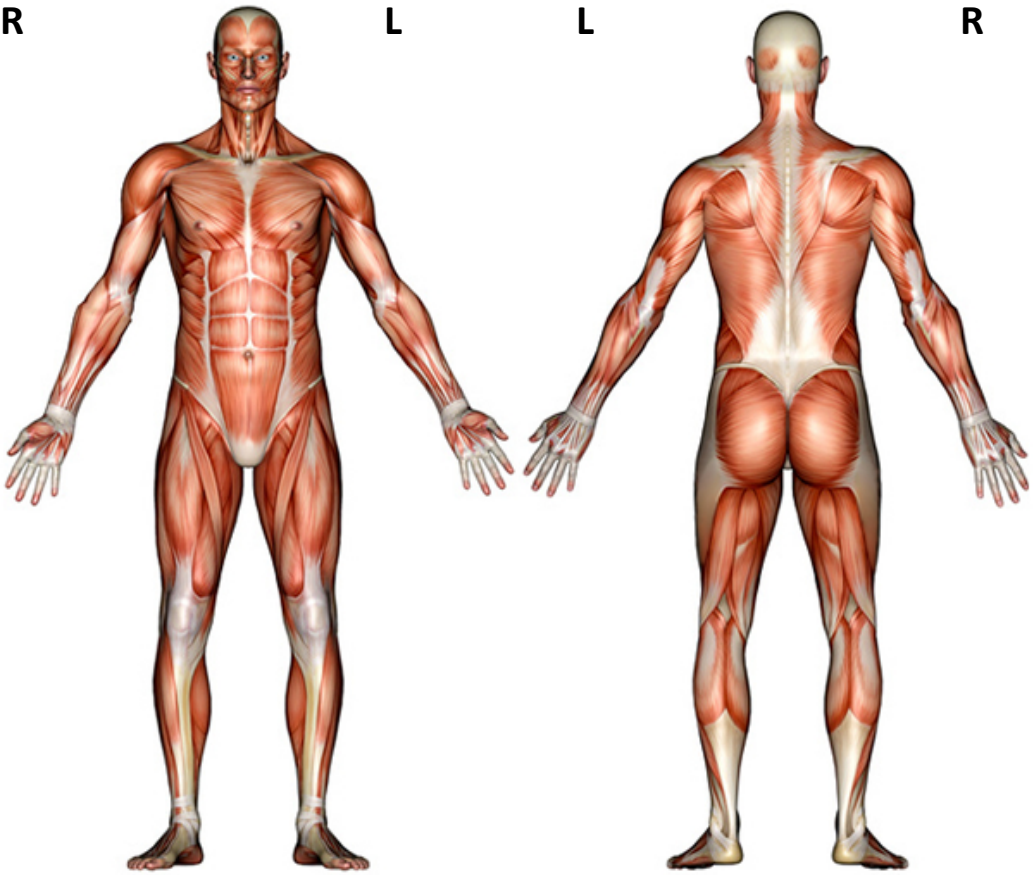
Female: Pregnant Y N Date of last Menstruation:_____ □Menstrual Cramps □Menopause

DESCRIBE YOUR PAIN:_____
_____
When did it start?_____What Happened?_____
Pain is: □ Sharp □ Dull/Ache □ Shooting □ Specific □ Constant □ Comes & Goes □ Numb □Tingling
Since it Began, is it: □ Same □ Slightly Improved □ Much Improved □ Worse □ Progressively Worse
What activities make it worse?_____
What activities make it better?_____
Is this condition better or worse at certain times of the day?_____
What is your current level of pain, on a scale of 1 to 10 with 10 being the worst:_____
Also rate level of pain during: Self Care_____ Work_____ Home Care_____ Hobbies_____ Social Life_____
Explain:_____
Have you seen a health care professional for this condition?_____
What have you done for this condition?_____

(Continue on Reverse Side)

Please draw your complaints below:

R **L** **L** **R**



SINCE THE ACCIDENT I HAVE EXPERIENCED:

- □ Headaches
- □ Neck Pain
- □ Numbness in Hands/Arms
- □ Pain/Numbness in Legs/Feet
- □ Low Back Pain
- □ Shoulder/Hip Pain
- □ Pain Between Shoulders
- □ Cold Hands/Feet
- □ Loss of Smell or Taste
- □ Dizziness
- □ Depression
- □ Drug Side Effects
- □ Lights Bother Eyes
- □ Loss of Balance
- □ Nervousness

□ Stiffness	□ Joint Swelling	□ Fever	□ Fatigue
□ Tension	□ Ringing in Ears	□ Jaw/TMJ Problems	□ Allergies
□ Diarrhea	□ Constipation	□ Upset Stomach	□ Heartburn/Reflux
□ Asthma	□ Chest Pain	□ Heart Attack	□ High Blood Pressure
□ Stroke	□ Cancer	□ Diabetes	□ Painful Urination

ALL PATIENTS: I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date:_____

INSURANCE PATIENTS: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me (patient). Furthermore, I understand that Stevens Creek Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor will be credited to my account upon 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 suspend payment or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable.

Patient Signature:_____ Date:_____

Thank you!