AUTO/INJURY/W.C. QUESTIONNAIRE

Name____Date____/____/_____File#_____________
Home Address____
City_____________________________________ State _____________Zip Code________________
Social Security #________/________/____________ Date of Birth_______/__________/__________
Home Phone: _____________________________Work Phone: _______________________________

Referred By: ____

Attorney Information:
Name: ____Phone # _________________
Address _______________________________City ____________State _______Zip _____________

Age____ Race: ( ) Caucasian ( ) Black ( ) Spanish ( ) Other________ Sex ( ) Male ( ) Female
1. Was the injury due to: ( ) Auto Accident ( ) Personal Injury ( ) Workman's Compensation
Date of Accident ____/____/______Time ____: ____am / pm
Place: ____
Where you the: ( ) Driver ( ) Passenger ( ) Pedestrian
If passenger where you sitting:
( ) Front Passenger ( ) Driver-Side Rear ( ) Passenger-Side Rear ( ) Other:_________________________

2. In your own words, please describe the accident in detail:
____
____
____
____

3. Where were you taken after he accident?
____

a) Were you wearing your seatbelt? ( ) Yes ( ) No

4. Did you have any physical complaints before the accident? ( )Yes ( )No
If yes, please describe in detail:
____
____

5. List dates of all prior Motor Vehicle Accident, Slip/Fall, Workers Comp injuries:
____
____

a) List all diagnostic tests & the facility performed at Ex: (MRI, SJ Radiology):
____
____
____

6. Since this Injury, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
Check Symptoms you have noticed:

___ Headaches	___ Irritability	___ Numbness in Toes	___ Face Flushed
___ Feet Cold	___ Neck Pain	___ Chest Pain	___ Short Breath
___ Buzzing Ears	___ Hands Cold	___ Neck Stiff	___ Dizziness
___ Fatigue	___ Balance Loss	___ Stomach Upset	___ Depression
___ Fainting	___ Constipation	___ Back Pain	___ Loss of Smell
___ Cold Sweats	___ Nervousness	___ Loss of Memory	___ Loss of Taste
___ Fever	___ Tension	___ Ears Ring	___ Diarrhea
___ Pins & Needles in Arms		___ Pins & Needles in Legs	___ Head Seems Too Heavy
___ Sleeping Problems		___ Light Bothers Eyes	___ Other: _____________________

For Office Use Only
Explain all paperwork/documents Y/N   Auto, WC, PI Information Y/N
Health Insurance Y/N   Signature on all Documents Y/N
Initials________ Comments ____

6. Have you been seen by another Dr. for this Accident? (   ) Yes (   ) No
   a) Are you: (   ) Improved (   )Unchanged (   ) Worse
   b) Are you taking any medications for this condition?

____

____

   c) Do these medications help? (   ) Yes (   ) No

7. Have you lost time from work as a result of the accident? (   ) Yes (   ) No
   If yes, please complete the questions below
   A. Last Day Worked ____/____/____
   B. Type of Employment?____
   C. Present Salary? ____
   D. Are you being compensated for the lost time from work? (   ) Yes (   ) No
      If yes, what type of compensation are you receiving? ____________________
   E. Have you ever had a previous worker's compensation claim? (   ) Yes (   ) No
      If yes, please explain: ____

8. How would you grade your pain on a scale of (1-10) 1 lowest – 10 Highest? ________________

9. How would you describe the pain?

___ Sharp ___ Soreness ___Throbbing ___ Dull ____Stiffness

___ Spasm ___ Burning ___ Weakness ___ Numbness ____ Shooting

10. How often is the pain present? ____Constant (80-100%) ____ Frequent (50-80%)
____ Occasional (26-50%) ____ Intermittent (25% or less)

11. What makes your problem better?

____

____

12. What makes your problem worse?

____

____

13. What is your physical activity at work?

____ Mostly Sitting _____ Light Manual Labor ____ Moderate Manual Labor _____ Heavy Manual Labor

Employer: ____________________________________ How Long?______________

Employer's Address: ____

____

Occupation: ____

We invite you to discuss with us any questions regarding out services. The best health services are based on a friendly, mutual understanding between provider and patient.
I authorize the staff to perform any necessary service needed during diagnosis and treatment. I also authorize the provider to release any information required to process claims.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize assignment of my insurance right and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not pain for by my insurance company. In the event that my insurance carrier forwards payment to me, I am solely responsible to forward that payment to your office within 30 days of receiving payment for treatment rendered.

Signature ____________________________________ Date _____/______/_________