Oak Springs Chiropractic:
A Creating Wellness
Center

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Personal Injury Questionnaire

Please invest a few moments to answer these questions so the Doctor can help you get better faster.

Name: _____ Date: _____

Sex: M or F
Marital Status: S M D W

Date of Birth: _____
Age: _____

Home Phone: ( ) ____ - _____
Cell Phone: ( ) ____ - _____

Email: _____
SSN: _____ - _____ - _____

Address: _____
City: _____ State: _____ Zip: _____

Employer/Occupation: _____
Work Phone: ( ) ____ - _____

SPOUSE/EMERGENCY CONTACT INFORMATION:

Name: _____ DOB: _____
Employer: _____ SSN: _____ - _____ - _____

Insurance Company
Name:_____ **Representative:**_____
Address_____ **City/State/Zip Code**_____
Phone:_____ **Claim number:** _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Injured at _____ City_____ State_____ Zip_____

In your own words, please describe the accident_____
_____

Please describe your **Primary** symptoms_____
_____

Level of Severity: low 1 2 3 4 5 6 7 8 9 10 high

When did the primary pain start? _____

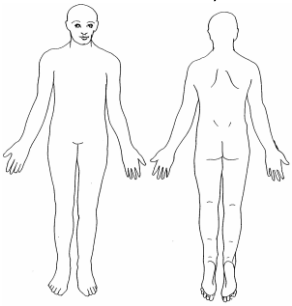
Please describe your **Secondary** symptoms_____

_____

Level of Severity: low 1 2 3 4 5 6 7 8 9 10 high

When did the secondary pain start? _____

Location and Radiation of symptom(s): mark with an X; use → for path of pain radiation if applicable



Quality of pain: (please circle all that apply)
Sharp Dull Numb Ache Shooting Burning Constant Intermittent Radiating

Have you been treated by another doctor for this accident? YES NO
If yes, please list doctor's name and address _____

Are you: IMPROVED UNCHANGED GETTING WORSE

What medications are you taking? _____

Prior to the accident, have you ever had any of the physical complaints similar to what you have now?
YES NO If yes, please describe _____

_____

Were these similar complaints the result of a previous accident(s)? YES NO
Please provide details of previous injury _____

_____

Have you missed work due to this accident? YES NO
If yes, please write dates of missed work _____

How is the injury affecting your work and homelife abilities? (Please circle any of the following that are affected by your injury)
Sitting Standing Walking Driving Housework Yardwork/Gardening Lifting Other_____

What work specific items are you not able to perform due to the injury? (Please list)

_____

_____

_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, whether or not my insurance company contributes. I hereby authorize the doctors at Oak Springs Creating Wellness Center and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practices of this office.

_____ _____

Patient's (Parent or Guardian's) Signature Date