BODY OF LIGHT FAMILY CHIROPRACTIC
Melody J. Spear, D.C.
David H. Spear, Ph.D., D.C.

PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name__________________________ DOB__________ Age _______ Sex M / F
Address ____
City ____________________ State______________ Zip ________________
Home # __________________ Work # ________________ SS# ____________
Employer__________________________Position/Duties__________________

YOUR AUTO INSURANCE INFO:

Your Ins. Co ____________ Policy # ______________ Agents name ____________
Name on policy (if other than self) ____________________

Claim #: ________________________ **Name of Adjuster:** ______________
Phone #: ________________________

INSURANCE INFO. ON VEHICLE INVOLVED IN ACCIDENT: (If accident occurred in vehicle other than your own)

Ins. Co. ________________________ Name of Adjuster: ______________
Claim #: ________________________ Phone #: ___________________

PERSONAL HEALTH INSURANCE: (Please provide your personal insurance information)

Ins Co. ________________________ Phone # ________________
Name on policy ____________________ Your Birth date: ____________
Ins ID # ________________________

INFORMATION ABOUT YOUR ATTORNEY: (if applicable)

Name ______________________ Phone #______________ Fax ____________
Address ________________________City __________ State ______ Zip ______

INFORMATION ABOUT YOUR ACCIDENT:

1. Date of accident __________ Location __________ Time of day __________
2. Name of street ________________________________
3. Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat
4. Number of people in your vehicle? __________
5. Were you wearing seat belts? ( ) Yes ( ) No
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
7. Direction of other vehicle? ( ) North ( ) South ( ) East ( ) West
8. Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side
9. Approximate speed of your car ________ mph type of vehicle ____________
10. Speed of other car ________ mph type of vehicle ____________
11. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?________
12. Were police notified? ( ) Yes ( ) No
13. Were there any witnesses? ( ) Yes ( ) No Names____________
14. Describe your body position at time of the accident ______________________
____
15. In your own words, please describe the accident ______________________
____

16. Please describe how you felt:

a. During the accident: ______________________________

b. Immediately after the accident: ______________________________

c. Later that day: ______________________________

d. The next day: ______________________________

17. Where were you taken after your current accident? ______________________________
____

18. Have you been treated by another doctor(s) since this accident? ( ) Yes ( ) No
If yes, please give name of doctor and type of treatment received:
i. ____________________ iii. ____________________
ii. ____________________ iv. ____________________

19. Did you have any physical complaints before the accident? ( ) Yes ( ) No
If yes, describe ______________________________
____

20. What are your present complaints and symptoms? ______________________________
____
____
____

21. Since this injury occurred are your symptoms ( ) Improving ( ) Getting worse ( ) Same

22. **CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

( ) headache	( ) irritability	( ) numbness-toes	( ) face flushed	( ) feet cold
( ) neck pain	( ) chest pain	( ) shortness breath	( ) buzzing in ears	( ) hands cold
( ) neck stiff	( ) dizziness	( ) fatigue	( ) loss of balance	( ) stomach upset
( ) sleep prob.	( ) head heavy	( ) depression	( ) fainting	( ) constipation
( ) back pain	( ) pins/needles-arms	( ) light sens. eyes	( ) loss of smell	( ) cold sweats
( ) nervousness	( ) pins/needles-legs	( ) loss of memory	( ) loss of taste	( ) fever
( ) tension	( ) numbness-finger	( ) ears ring	( ) diarrhea	

( ) Symptoms other than above ______________________________

23. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last day worked: ______________________________
b. Type of employment: ______________________________

24. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe ______________________________
____
____
____
____

Present State of Health (Presenting Symptoms). Please list your complaints in order of intensity. Please only list those that are a result of your most recent motor vehicle accident.

1st Present Complaint: ______________________________

When did this issue begin? ______________________________

Describe symptom (sharp/dull/numb etc.) ______________________________
Severity (0-10; 10= most severe) ______________________________
Do you have radiating symptoms (numbness/tingling/pain) into your arms or legs? ______________________________

Is the symptom: getting better staying the same getting worse
Aggravated by? ______________________________
Helped by? ______________________________
Is the condition worse at a specific time of day? ______________________________

How does the symptom(s) interfere with your life? (ie: sleep/work/play/lifting children etc.)
____

Have you seen other doctors for this condition(s)?______________________________
Results? ______________________________

2nd Present complaint: ______________________________

When did this issue begin? ______________________________

Describe symptom (sharp/dull/numb etc.) ______________________________
Severity (0-10; 10= most severe) ______________________________
Do you have radiating symptoms (numbness/tingling/pain) into your arms or legs? ______________________________

Is the symptom: getting better staying the same getting worse
Aggravated by? ______________________________
Helped by? ______________________________
Is the condition worse at a specific time of day? ______________________________

How does the symptom(s) interfere with your life? (ie: sleep/work/play/lifting children etc.)
____

Have you seen other doctors for this condition(s)?______________________________
Results?

3rd Present complaint: ______________________________

When did this issue begin? ______________________________

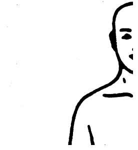
Describe symptom (sharp/dull/numb etc.) ______________________________
Severity (0-10; 10= most severe) ______________________________
Do you have radiating symptoms (numbness/tingling/pain) into your arms or legs? ______________________________

Is the symptom: getting better staying the same getting worse
Aggravated by? ______________________________
Helped by? ______________________________
Is the condition worse at a specific time of day? ______________________________

How does the symptom(s) interfere with your life? (ie: sleep/work/play/lifting children etc.)
____

Have you seen other doctors for this condition(s)?______________________________
Results? ______________________________

25. Please indicate on the diagrams where and what type of symptoms you are experiencing since the accident.



A=ACHE	B=BURNING	N=NUMBNESS
P=PINS & NEEDLES	S=STABBING	O=OTHER

AUTHORIZATION FOR EXAM (CARE) / BILLING INSURANCE:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I acknowledge that I have read through and agree to the authorization for care and insurance policies described above.

Signature: ____ Date: ____/____/_____