BODY OF LIGHT FAMILY CHIROPRACTIC

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PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU

Name_____ DOB_____ Age _____ Sex:_____
Address _____
City _____ State_____ Zip _____
Cell/Home # _____ Work # _____ Employer_____

YOUR AUTO INSURANCE INFO:

Your Ins. Co _____ Policy # _____ Agents name _____

Claim #: _____ **Name of Adjuster:** _____
Phone #: _____

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

Ins Co. _____Ins ID # _____

INFORMATION ABOUT YOUR ATTORNEY: (if applicable)

Name _____ Phone #_____ Fax _____

INFORMATION ABOUT YOUR ACCIDENT:

1. Date of accident _____ Location _____
2. Were you the: Driver Passenger Front seat Back seat
3. Number of people in your vehicle? _____
4. Were you wearing seat belts? Yes No
5. What direction were you headed? North South East West
6. Direction of other vehicle? North South East West
7. Were you struck from Behind Front Left side Right side
8. Approximate speed of your car _____ mph type of vehicle _____
9. Speed of other car _____ mph type of vehicle _____
10. Were you knocked unconscious? Yes No If yes, for how long?_____
11. Were police notified? Yes No
12. Were there any witnesses? Yes No
13. Describe your body position at time of the accident:
    Facing forward Looking down Right arm raised Lying down in back seat
    Looking Right Braced/stiff arms Left arm raised
    Looking Left Braced/stiff legs Lying down in passenger seat
    Other:_____
14. Did you see the impact coming? Yes No
15. Did the airbag deploy? Yes No
16. Did the EMS respond to the accident? Yes No
17. Were you able to drive after the accident? Yes No Car Towed
18. Please describe your symptoms immediately after the accident:

19. Where were you taken after your accident?
    _____

20. 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:
1. _____ 3. _____
2. _____ 4. _____

21. Did you have any physical complaints before the accident? Yes No
If yes, describe:
_____

22. Where are your present complaints and symptoms?

Left Neck	Left Low Back	Left Shoulder	Left Hip
Center Neck	Center Low Back	Right Shoulder	Right Hip
Right Neck	Right Low Back	Left Arm	Left Leg
Left Upper Back	Left Pelvis	Right Arm	Right Leg
Center Upper Back	Center Pelvis	Left Hand	Left Lower Leg
Right Upper Back	Right Pelvis	Right Hand	Right Lower Leg
Left Mid Back			Left Foot
Center Mid Back			Right Foot
Right Mid Back			

23. Since this injury occurred are your symptoms Improving Getting worse Same

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

headache	irritability	numbness-toes	face flushed	cold sweats
neck pain	chest pain	shortness breath	buzzing in ears	fever
neck stiff	dizziness	fatigue	loss of balance	nervousness
sleep prob.	head heavy	depression	fainting	tension
back pain	pins/needles-arms	pins/needles legs	ears ringing	memory loss
light sensitivity	numbness-finger			

Symptoms other than above _____

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

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

26. Do you notice any activity restrictions as a result of this injury? Yes No
If yes, please describe

27. In your own words, please describe the accident (i.e. stopped at a traffic light when struck from behind which spun my car into oncoming traffic):

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? _____

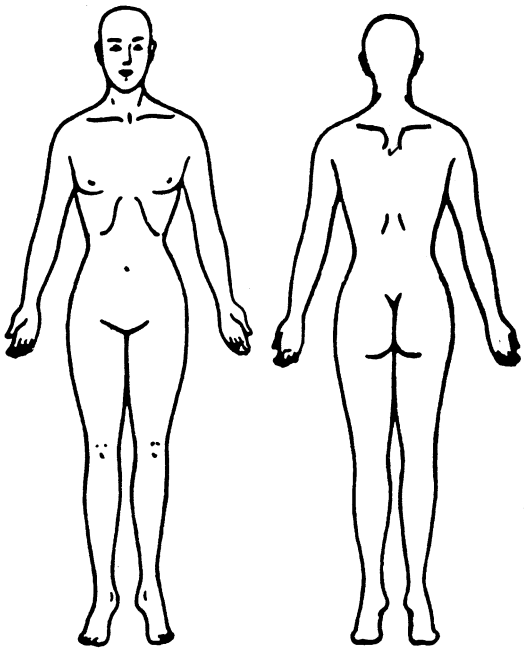
Describe symptom (sharp/dull/numb etc.) _____
Severity (0-10; 10= most severe) _____
Do you have radiating symptoms (numbness/tingling/pain) into your arms or legs? _____

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: ____/____/_____

STOP here if you are NEW to Body of Light.

If you have received care in our office prior to your accident, please continue to the next page.

To our current clients:
It is important that we are able to differentiate between the symptoms (if any) that we have been treating you for and your current symptoms that are a result of the accident. Use a new page for each area (neck, lower back, etc).

Please compare your symptoms **before** and **after** the accident:

	Pre-MVA	**Post-MVA**
Presenting Symptoms:	_____	_____
Describe Symptom (sharp/dull/numb etc.)	_____	_____
Rate the intensity of the pain (1-10, 10 being most severe):	_____	_____
Was/Is the symptom getting better, staying the same, or getting worse?	_____	_____
Aggravated by?	_____	_____
Helped by?	_____	_____
How did/does the symptom interfere with activity? (ie: sleep/work/play/ lifting children etc.)	_____	_____

	Pre-MVA	**Post-MVA**
Presenting Symptoms:	_____	_____
Describe Symptom (sharp/dull/numb etc.)	_____	_____
Rate the intensity of the pain (1-10, 10 being most severe):	_____	_____
Was/Is the symptom getting better, staying the same, or getting worse?	_____	_____
Aggravated by?	_____	_____
Helped by?	_____	_____
How did/does the symptom interfere with activity? (ie: sleep/work/play/ lifting children etc.)	_____	_____