UPPER CERVICAL Wellness Center
LEADING YOU TO A HEALTHIER LIFE

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Phone: _____

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

Age: _____ Birth Date: _____ Sex: M F S/S#: _____

Employer's Name: _____

Employer's Address: _____

Auto Insurance Company: _____

Policy #: _____ Agent's Name: _____

Address: _____ City: _____ State: _____Zip: _____

Name on Policy (if other than self): _____

Responsible Party's Name: _____

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

Attorney
Name: _____ Phone: _____

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

Were there any witnesses? YES NO

Name: _____ Phone: _____

Nature of Accident

1. Date of accident: _____ Time of day: _____
2. Were you: Driver _____ Passenger _____ Front Seat _____Back Seat _____
3. Number of people in your vehicle: _____
   Were you wearing seat belts? YES NO
4. What direction were you headed? North _____ South _____ East _____West _____
   On (Name of street): _____
5. What direction was the other vehicle headed? North South East West
   On (Name of street): _____
6. Were you struck from: Behind Front _ Left side Right side
7. Approximate speed of you vehicle: mph Other car: mph
8. Were you knocked unconscious? YES NO
9. Were police notified? YES NO
10. In your own words, please describe the accident:

_____

_____

11. Did you have any physical complaints before the accident? _____YES _____NO
    If yes, please describe in detail: _____

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PERSONAL INJURY QUESTIONNAIRE (continued)

12. Please describe how you felt:
    a. During the accident: _____
    b. Immediately after the accident: _____
    c. Later that day: _____
    d. The next day: _____

13: What are your PRESENT complaints and symptoms? _____
_____

14. Do you have any congenital (from birth) factors which relate to this problem? YES NO
15. Do you have any previous illnesses which relate to this cause? YES NO
    If yes, please describe: _____
16. Have you ever been involved in an accident before? YES NO
    If yes, please describe, including date(s), type(s) of accidents, as well as injury(ies) received: _____
    _____
17. Where were you taken after the accident?
_____
18. Have you been treated by another doctor since the accident? YES NO
If yes, please list the doctor's name and address: _____

19. Since the injury occurred, are your symptoms: Improving Getting Worse Same

20. Circle the symptoms you have noticed since the accident:

Headache	Neck Pain	Neck Stiff	Sleeping Problems
Back Pain	Nervousness	Tension	Irritability
Chest Pain	Dizziness	Head Seems Too Heavy	Cold Sweats
Pins and Needles in Arms	Pins and Needles in Legs	Numbness in Fingers	Feet Cold
Hands Cold	Numbness in Toes	Shortness of Breath	Fatigue
Depression	Lights Bother Eyes	Loss of Memory	Ears Ring
Face Flushed	Buzzing in Ears	Loss of Balance	Fainting
Loss of Smell	Loss of Taste	Diarrhea	Stomach Upset
Constipation	Fever		

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Other Symptoms Other Than Above: _____
21. Have you lost time from work as a result of this accident? YES NO
    If yes, when was the last day worked: _____
22. Do you notice any activity restrictions as **a** result of this injury? YES NO
    If yes, please describe in detail: _____
    _____

_____ _____
Patient Signature Date

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MEDICAL PAY INSURANCE/LIEN & AUTHORIZATION

Patient Name: _____

Claim or File #: _____

Date of Loss: _____

I hereby authorize and direct you my insurance company liability insurance adjuster, to pay directly to Upper Cervical Wellness Center sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold sums from disability benefits, medical payment benefits, No Fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect this Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their opinion. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to pay all costs of collection of any balance due this Office, including reasonable attorney fees. This agreement is made solely for said provider's additional protection and in consideration of the Medical Service Provider awaiting payment in this matter.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. A photocopy of this Agreement shall be considered as effective and valid as the original.

Date: _____ Signature:_____

Witness:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

Date: _____ Signature: _____

Note to attorney: If you prefer, please send your acknowledgment of this lien on your letterhead