VFC Personal Injury Questionnaire

Personal Information

Name _____ Sex _____ Age _____ DOB _____
Address _____ City _____ State _____ Zip _____

Phone # _____ Occupation _____ Affected by accident Y N
Have you missed work due to the accident Y N How many days ___

Email address _____ Martial Status S M W L/W

Any history of pain in your spine Y N Location _____ Last episode _____
Do you have any joint replacements Y N Location _____ Date performed _____
Any history of (circle all that apply) Anxiety Depression Dizziness Seizures Headaches Diabetes

Numbness Stoke Sleep issues Difficulty concentrating Cancer
Eye problems Ear problems Difficulty swallowing Heart attack
High blood pressure Low blood pressure High cholesterol
Chest pain Asthma Shortness of breath Abdominal pain
Constipation Heartburn Hemorrhoids Reflux

Previous surgeries or hospitalizations _____
Medications currently taking _____
Previous accidents _____
What do you do for exercise _____ Changed since accident Y N

Insurance Information

Car Insurance Company _____ Claim Number _____
Address where bills sent _____
Adjustor _____ Phone number _____
Name of Attorney (if you retained one) _____
Attorney Address _____
Attorney Phone number _____

Accident Information

Date of Accident _____ Location _____
Were you the (circle one) Driver Passenger Pedestrian Cyclist
Were you struck from (circle) Front Left side Right side Rear Trailer hitch
Was your vehicle (circle) Backing up Moving forward Stopped Turning N/A
Other vehicle movement (cir) Backing up Moving forward Stopped Turning
Approximate speed of your vehicle _____ Approximate speed of other vehicle _____
Vehicle damage (circle) Heavy Moderate Slight None Totaled
Damage to other vehicle (cir) Heavy Moderate Slight None Totaled
Was your vehicle towed from the scene (circle) Y N
EMS at the scene (circle) Y N Police at the scene (circle) Y N
Did you go to the hospital (circle) Y N If yes, what did they do there _____
Did you seek any medical care following the accident (circle) Y N If yes, where _____
What was done _____
Did you strike the interior of the vehicle Y N If yes, what part of the body came in contact (head, shoulder) _____ What did the body part contact in the vehicle (airbag, steering wheel) _____
Did you hit your head (circle) Y N Did you lose consciousness (circle) Y N
Explain the accident _____

126 Harvard St., Brookline MA 02446 FrontDesk@VillageChiro.com (617) 566-2001

VFC Personal Injury Questionnaire

Symptom #1: _____
When did you first notice the symptom?_____
Have you ever had this symptom prior to the accident? Y N If yes, please describe _____
Where is the symptom located?_____
Does the symptom travel to another part of the body? Y N Where? _____ How often? _____
Describe the symptoms: (dull, achy, sharp, stabbing, numb, tingling)_____
_____
How often are you experiencing the symptom (circle one): constant, few times a day , few times a week
How long does the symptom last once it begins _____
On a scale of 1-10, (1= barely noticeable, 10= mauled by a shark) how would you rate this symptom: _____
Can you do anything to make the symptom less noticeable? _____
What makes the symptom worse _____
Have you sought any other treatment for this symptom _____
How have the symptoms changed since the accident (circle) Improved Stayed the same Worsened
What activities are difficult to do, because of this symptom (circle all that apply)
Work/School Homemaking Lifting Personal care (washing, dressing) Sitting
Sleeping Social Life Standing Driving Walking Exercising
How long are you able to do the above activity before the symptom starts: ___ minutes/hours

Symptom #2: _____
When did you first notice the symptom?_____
Have you ever had this symptom prior to the accident? Y N If yes, please describe _____
Where is the symptom located?_____
Does the symptom travel to another part of the body? Y N Where? _____ How often? _____
Describe the symptoms: (dull, achy, sharp, stabbing, numb, tingling)_____
_____
How often are you experiencing the symptom (circle one): constant, few times a day , few times a week
How long does the symptom last once it begins _____
On a scale of 1-10 (1= barely noticeable, 10= mauled by a shark) how would you rate this symptom: _____
Can you do anything to make the symptom less noticeable? _____
What makes the symptom worse _____
Have you sought any other treatment for this symptom _____
How have the symptoms changed since the accident (circle) Improved Stayed the same Worsened
What activities are difficult to do, because of this symptom (circle all that apply)
Employment Homemaking Lifting Personal care (washing, dressing) Sitting
Sleeping Social Life Standing Driving Walking Exercising
How long are you able to do the above activity before the symptom starts: ___ minutes/hours

PLEASE READ AND SIGN

I have been informed that a copy of Village Family Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on the website www.villagechiro.com.

I consent to receive communication from Village Family Chiropractic via email postal mail, text and telephone messaging in connection with my care

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Lisa Geiger, D.C. and Jillian London, D.C. permission to render care to me today.

I authorize the release of any information necessary to process the claim regarding the accident listed above.

_____ _____ _____
Patient's Signature/Signature of Guardian Patient's Name Printed Date

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VFC Personal Injury Questionnaire

Symptom #3: _____
When did you first notice the symptom?_____
Have you ever had this symptom prior to the accident? Y N If yes, please describe _____
Where is the symptom located?_____
Does the symptom travel to another part of the body? Y N Where? _____ How often? _____
Describe the symptoms: (dull, achy, sharp, stabbing, numb, tingling)_____
_____
How often are you experiencing the symptom (circle one): constant, few times a day , few times a week
How long does the symptom last once it begins _____
On a scale of 1-10, (1= barely noticeable, 10= mauled by a shark) how would you rate this symptom: _____
Can you do anything to make the symptom less noticeable? _____
What makes the symptom worse _____
Have you sought any other treatment for this symptom _____
How have the symptoms changed since the accident (circle) Improved Stayed the same Worsened
What activities are difficult to do, because of this symptom (circle all that apply)
Work/School Homemaking Lifting Personal care (washing, dressing) Sitting
Sleeping Social Life Standing Driving Walking Exercising
How long are you able to do the above activity before the symptom starts: ___ minutes/hours

Symptom #4: _____
When did you first notice the symptom?_____
Have you ever had this symptom prior to the accident? Y N If yes, please describe _____
Where is the symptom located?_____
Does the symptom travel to another part of the body? Y N Where? _____ How often? _____
Describe the symptoms: (dull, achy, sharp, stabbing, numb, tingling)_____
_____
How often are you experiencing the symptom (circle one): constant, few times a day , few times a week
How long does the symptom last once it begins _____
On a scale of 1-10, (1= barely noticeable, 10= mauled by a shark) how would you rate this symptom: _____
Can you do anything to make the symptom less noticeable? _____
What makes the symptom worse _____
Have you sought any other treatment for this symptom _____
How have the symptoms changed since the accident (circle) Improved Stayed the same Worsened
What activities are difficult to do, because of this symptom (circle all that apply)
Work/School Homemaking Lifting Personal care (washing, dressing) Sitting
Sleeping Social Life Standing Driving Walking Exercising
How long are you able to do the above activity before the symptom starts: ___ minutes/hours

VFC Personal Injury Questionnaire

HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c. 90, Sec. 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below. Thank you very much.

1. Do you have Health Insurance? ( ) YES ( ) NO

If yes, please answer, or provide a copy of your health insurance card.

Plan Name:

Address:

Telephone:

Group Number: Policy Number:

Subscriber Name:

ID Number:

B. If no,

Are you eligible for coverage under someone else's health plan? ( )YES ( )NO

If you are eligible under someone else's health plan, please indicate their name and your relationship to the plan member, etc. below and complete the above information as it pertains to the plan.

Member Name:

Relationship:

Address of Member:

Member Phone:

Applicant's signature: _____

Applicant's name (printed): _____

Date: _____

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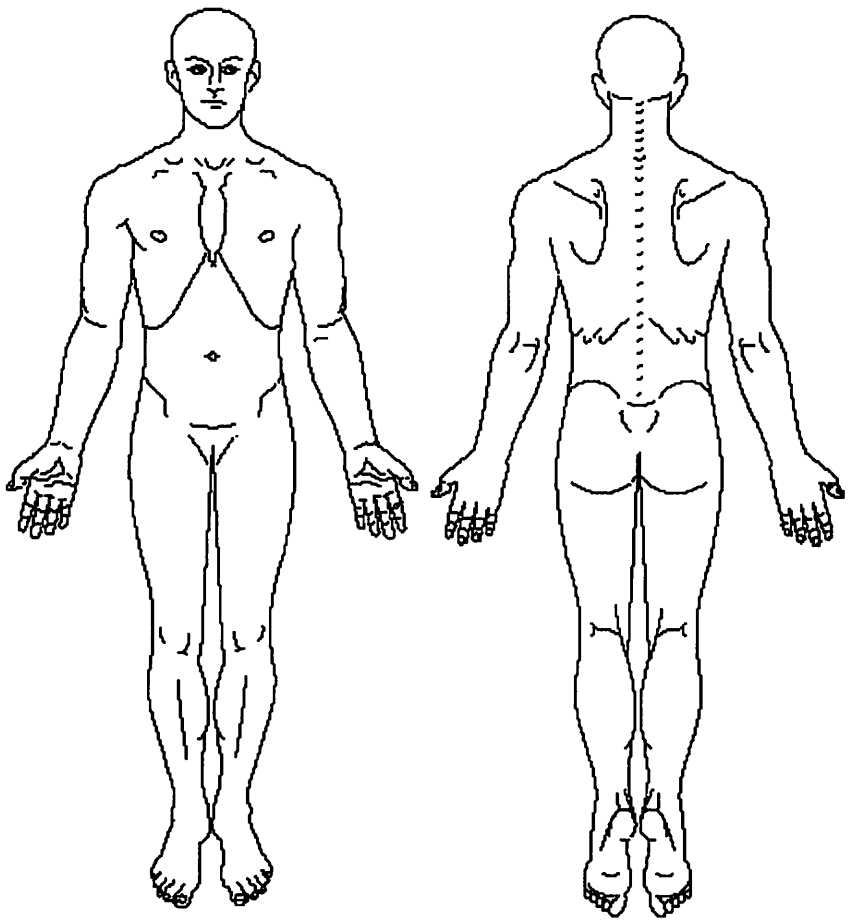
NAME:_____ **Date:**_____ _____

PAIN DRAWING

SHADE IN WITH A PEN ALL AREAS YOU HAVE PAIN.
(Don't forget to include the head or areas of lesser pain).
Use small x's to show any areas of numbness or tingling



Please mark on the line, the pain level that most accurately represents your pain for each body area:

	0	1	2	3	4	5	6	7	8	9	10
Right now:	No pain										Unbearable
Average pain:	No pain										Unbearable
At best & worst:	No pain										Unbearable

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date