ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)________________________ **Today's Date:** ________

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ No ☐ Yes - *(Number of people)* ______
- **You were?** ☐ Front seat – *Driver / Passenger* ☐ Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: ______________ **Name of Driver of other vehicle:** ______________
- **Did airbags deploy?** ☐ No ☐ Yes **Did Police arrive?** ☐ No ☐ Yes **Using Seatbelt?** ☐ No ☐ Yes
- **Did you strike the windshield or object in car?** ☐ No ☐ Yes - *(Describe)* ______________
- **Were you knocked unconscious?** ☐ No ☐ Yes *(How long?)* ________
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ______________
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ______________
- **Your Auto Ins:** ____________ **Policy #:** ____________ **Claim #:** ____________ **Phone #:** ____________
  - **Address:** ____________ **City:** ____________ **State:** ______ **Zip:** ________
- **Other's Auto Ins:** ____________ **Policy #:** ____________ **Claim #:** ____________ **Phone #:** ____________
  - **Address:** ____________ **City:** ____________ **State:** ______ **Zip:** ________

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: ______________ **Occupation:** ____________ **Claim #:** ____________
Address: ______________ **City:** ____________ **State:** ______ **Zip:** ________
Contact Person: ______________ **Phone:** ____________ **Email:** ____________

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ___/___/_____ **Time:** ___:_____ AM / PM

Please describe the accident in as much detail as possible? ______________________________

____

____

____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ No ☐ Yes
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ No ☐ Yes
    - *If yes* - **Summarize these complaints prior to the accident:** ______________
- **Were you capable of performing all of your work activities without restriction?** ☐ No ☐ Yes

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? ________
- **Were you taken anywhere after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? ________
  - *If yes*, **How?**______________ **Where?**______________
  - *If yes*, **Did you receive treatment?** ☐ No ☐ Yes - *(Describe)* ______________

Since the accident/injury:

- **Are your symptoms:** ☐ Improving? ☐ Getting Worse? ☐ The Same?
- **Are your work activities restricted as a result of this accident/injury?** ☐ No ☐ Yes - *(How?)* ______________
- **Have you missed any work since this accident?** ☐ No ☐ Yes - *(Dates?)* ______________
- **Have you retained an Attorney?** ☐ No ☐ Yes - **Name:**______________ **Phone:** ____________
  - **Address:** ______________ **City:** ____________ **State:** ______ **Zip:** ________

Patient No: ________

© Pinnacle Management Group, Inc. 2013

COMPLAINT INFORMATION

Date: ______________ **Patient No:** ___________

History of Current Condition

Major Complaint: ____

Secondary Complaint: ____

When and How this began? ____

____

____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) ______________

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: ______________

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ______________

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ______________

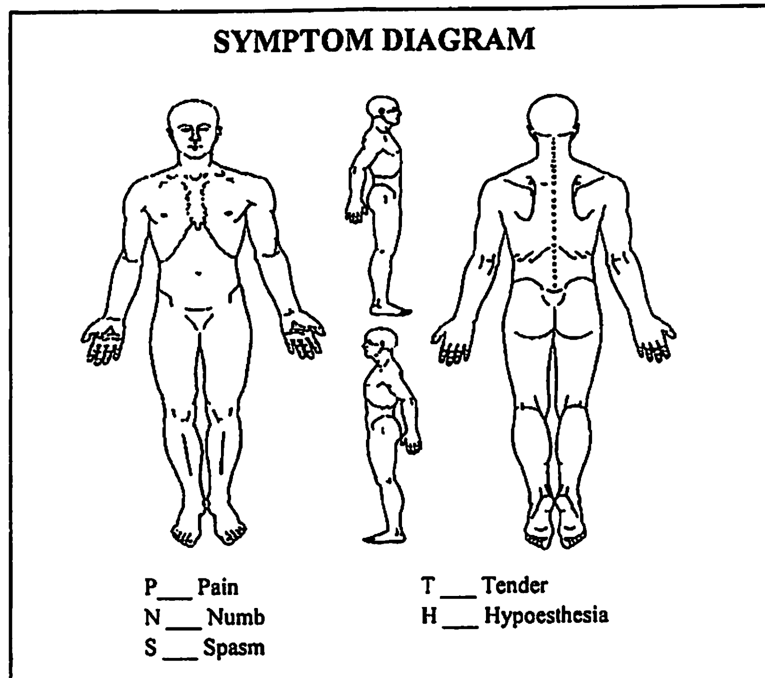
Which daily activities are being affected? (*Describe*) ______________

For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: ______________ **Where:** ______________

Other Diagnostic Testing? X-rays / MRI / CT / Other: ______________ **Where:** ______________

Pain Complaint Diagram



Patient Signature: ______________________________ ***Physician's Initials:*** ___________

REVIEW OF SYSTEMS

Patient Name: (First MI Last) ____________________ **Patient No:** __________

Review of Systems

Zone 1 Glandular System:
- ☐ Memory Loss
- ☐ Sleep
- ☐ Skin
- ☐ Hair
- ☐ Menstrual
- ☐ Thyroid/Energy
- ☐ Adrenals
- ☐ Anxiety/Depression
- ☐ ED/Fertility
- ☐ Hot Tempered
- ☐ Unable to Concentrate
- ☐ Low Immunity

Zone 2 Eliminative System:
- ☐ Sinuses
- ☐ Throat
- ☐ Kidneys
- ☐ Bladder
- ☐ Intestines/Colon
- ☐ Nasal Passages
- ☐ Lungs
- ☐ Bronchitis/Pneumonia
- ☐ Lymphatic
- ☐ Bloating/Toxins

Zone 3 Nervous System:
- ☐ Eyes
- ☐ Balance/Dizziness
- ☐ Poor Sleep
- ☐ Solar Plexus
- ☐ Unable to Relax
- ☐ Nervousness
- ☐ Ears
- ☐ Tingling in Extremities
- ☐ Allergies/Food Issues
- ☐ Digestion
- ☐ Tensions
- ☐ Hormone Imbalances

Zone 4 Digestive System:
- ☐ Appetite
- ☐ Acid Reflux
- ☐ Liver
- ☐ Stomach
- ☐ Intestines
- ☐ Digestion
- ☐ Taste
- ☐ Heartburn
- ☐ Gallbladder
- ☐ Pancreas
- ☐ Weight Gain
- ☐ Elimination

Zone 5 Muscular System:
- ☐ Neck
- ☐ Arms/Hands
- ☐ Middle Back
- ☐ Legs/Feet
- ☐ Abdomen
- ☐ Disc Problems
- ☐ Shoulders
- ☐ Upper Back
- ☐ Lower Back
- ☐ Chest
- ☐ Weakness
- ☐ Muscle/Joint Pain

Zone 6 Circulatory/Lymphatic System:
- ☐ Thyroid
- ☐ Blood Pressure
- ☐ Heart Problems
- ☐ Headaches/Migraines
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Poor Circulation

Health History

Medications and Supplements:

Allergies to Medications: ☐ NONE

Name	Reaction

Current Medications & Supplements: ☐ NONE

Name	Dosage

Past Health History:

Surgeries: ☐ NONE

Date	Describe

Major Injuries / Traumas / Hospitalizations: ☐ NONE

Date	Describe

Family Health History: ☐ NONE

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐ Every Day ☐ Some Days ☐ Former ☐ Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

LIEN, ASSIGNMENT AND AUTHORIZATION/DIRECTIONS TO PAY DOCTOR
(Personal Injury)

Dr. Russ Corey, DC
Corey Chiropractic
2705 S. 148th St Omaha, NE 68144

Patient Name:______________________ Address:____

Other Parties: Name(s)____

Address:____

Date of Injury:__________________ Location:____

In consideration of the above-cited doctor (and/or Corey Chiropractic) undertaking to render care to me related to injuries and disabilities arising out of, or related to the incident referred to above I agree as follows:

1) The doctor (Corey Chiropractic- Dr. Russ Corey) is hereby granted a lien on any and all sums due and/or payable to me based upon any judgment(s), verdict(s), or out of the proceeds of any settlement related to the above-cited incident and which are based, in whole or in part on charges made for the services rendered to me by said doctor or doctor's office.

2) Pursuant to Section 52-401 of the Nebraska Revised Statues I hereby also expressly assign to said doctor (Corey Chiropractic-Dr Russ Corey) any and all rights and privilege. I might now have, or which I might hereafter acquire, to the payment of the charges made for the services rendered to me by said doctor or doctor's office.

3) The foregoing lien and/or assignment shall apply to at least the following: A.) Any and all attorneys retained to represent me in the cited case and any other attorneys associated on the case by any attorney hired by me. B.) Sums payable by any and all insurance carriers, managed care or other entity or entities care practitioners. C.) Sums payable, or agreed to be paid, by any and all insurance or indemnity company or companies with liability coverage for the referenced event for, or on behalf of, the third party or parties referred to above and/or as to the vehicle operated and/or owned by them. D.) Any and all other person, persons or company otherwise obligated to pay for damages and injuries caused by the reference third party or parties or as to the referenced vehicle.

4) Each of the persons and entities referred to in the preceding paragraphs 3 (a)(b)(c) and (d) are hereby expressly authorized, instructed and directed to make payment directly to my doctor (or doctor's office) of all sums due for charges for services rendered to me relative to the cited incident as provided for by the lien(s) and/or assignment(s) granted hereby.

5) The doctor (doctor's office) is hereby authorized to release to any and all persons and entities identified in paragraphs 3 (a)(b)(c) and (d) information, records and reports about my injuries, disabilities, condition, diagnosis, examination(s) and treatment relative to the care rendered to me related to this incident.

6) I understand that I am directly and fully responsible to the doctor (doctor's office) for payment of all the medical bills for care related to this incident. I further agree that I will pay all of my doctor (doctor's office) charges except as all or a part thereof are, within a reasonable time after the bill is submitted, actually paid pursuant to this agreement. Any bills paid by third persons after the patient has paid said bills are to be immediately reimbursed to the patient by the doctor (doctor's office).

Dated ____________________ ________________________________
Patient's Signature

I, ________________________, the undersigned, do hereby agree to comply with the terms and provisions above stated and I expressly agree to honor the doctor's (doctor's office) lien and to withhold and pay over the doctor (Corey Chiropractic- Dr Russ Corey) from such sums as may be paid to my client due to the cited incident as are needed to pay all sums due for services rendered with respect to the referenced incident.

Dated ____________________ ________________________________
Insurance Company/Attorney Signature