A Family Chiropractic a Bravo Inc.

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of birth: _____

Phone #: _____ Email: _____

Sex assigned at birth: _____ Gender: _____ Pronouns: _____

Address: _____ Apt: _____

City, state, zip code: _____

Employer/occupation: _____

Emergency contact: _____ Phone #: _____

Your car insurance company: _____ Policy #: _____

Claim adjustor: _____ Phone #: _____

Claim number: _____

Attorney name: _____ Phone #: _____

Address: _____

Other party involved:

Name: _____

Car insurance company: _____ Driver's policy #: _____

Address: _____

Claim adjustor: _____ Phone #: _____

Claim number: _____

Attorney name: _____ Phone #: _____

Address: _____

Who was the responsible party: _____

Was there a police report filed? _____ **If yes, please provide a copy.**

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1. Nature of accident: _____ Date/time of accident: _____

2. Were you: Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐

3. Number of people in the vehicle: _____ Number of people wearing seatbelts: _____

4. What direction were you headed: North ☐ South ☐ East ☐ West ☐

Name of street: _____

5. What direction was the other vehicle heading: North ☐ South ☐ East ☐ West ☐

Name of street: _____

6. Were you struck from: Behind ☐ Front ☐ Left side ☐ Right side ☐

7. Approximate speed of your car: _____ Other car: _____

8. Were you knocked unconscious: Yes ☐ No ☐ If yes, for how long: _____

9. Were the police notified: Yes ☐ No ☐

10. In your own words, please describe the accident: _____

_____

_____

11. Did you have physical complaints BEFORE THE ACCIDENT: Yes ☐ No ☐

If yes, please describe in detail: _____

_____

12. Please describe how you felt:

a) During the accident: _____

b) Immediately after: _____

c) Later that day: _____

d) The next day: _____

13. What are your present complaints/symptoms: _____

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14. Do you have any congenital (from birth) factors which relate to these problems: Yes ☐ No ☐

If yes, please describe in detail: _____

_____

15. Do you have any previous illnesses which relate to this case: Yes ☐ No ☐

If yes, please describe in detail: _____

_____

16. Have you been involved in an accident before: Yes ☐ No ☐

If yes, please describe in detail: _____

_____

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 Doctor's name and address: _____

_____

19. Since this injury occurred, are your symptoms: Same ☐ Improving ☐ Getting worse ☐

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck pain	☐ Chest pain	☐ Shortness of breath	☐ Buzzing in ears	☐ Hands cold
☐ Neck stiffness	☐ Dizziness	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Sleeping problems	☐ Head seems too heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back pain	☐ Pins & needles in arms	☐ Light bothers eye	☐ Loss of smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Tension	☐ Numbness in fingers	☐ Ears ring	☐ Diarrhea	

Additional symptoms: _____

_____

21. Have you lost time from work as a result of this accident: Yes ☐ No ☐

a) Type of employment: _____

b) Last day worked: _____

c) Present salary: _____

d) Are you being compensated for time lost at work: Yes ☐ No ☐

If yes, please state type of compensation you are receiving: _____

_____

22. Do you notice any restrictions as a result of this injury: Yes ☐ No ☐

If yes, please describe in detail: _____

_____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

1. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Name _____ Patient/Guardian Signature _____ Date _____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE CHIROPRACTIC INFORMED CONSENT TO TREAT

I have read the attached explanation of the chiropractic adjustment and related treatment. I have discussed it with my treating doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name _____ Patient/Guardian Signature _____ Date _____

Witness Name _____ Witness Signature _____ Date _____

Authorization

Our office policy maintains that payment is due at the time service is rendered. This includes your co-pay or deductible.

Please be prompt in keeping appointments. If you need to re-schedule an appointment, kindly give us 24-hour notice, otherwise you are subject to a fee for the time we have reserved for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the chiropractor. I understand that my chiropractic insurance company may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or dependents.

Patient Name _____ Patient/Guardian Signature _____ Date _____

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Consent Form

Thank you for participating in our social media page. We would greatly appreciate you filling out this form to get an understanding of how and where we are permitted to use your photographs. We plan to use these photographs as an educational and marketing tool.

I _____ hereby give permission for posting our photographs on:

(Please check all that apply)

☐Facebook ☐Office ☐Instagram ☐Website ☐Newsletter ☐Yelp/Google

AND

Hereby give permission for releasing the following marked information:

(Please check all that apply)

☐First Name ☐Name of my Condition ☐Image ☐Video ☐Testimonial Quote

OR

I _____ DO NOT GIVE PERMISSION TO POST OR USE ANY PHOTOGRAPHS/VIDEOS.

Additional Comments: _____

_____

_____

I consent to use my videos, photographs, on the above checked off sections indicated by me and I understand thatI can always revoke this consent by contacting our office in writing.

Signature: _____ Date: _____

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