Automobile/PI Accident Questionnaire

Patient's Name _______________ **Date of Birth** _______________ **ID#:** _______________

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. **We will not accept your case if we do not believe your condition will respond satisfactorily to care.** In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: ___________________________________

____

____

What were the time and date of present injury? ___________________________________

Where did you feel pain immediately after the accident? ___________________________________

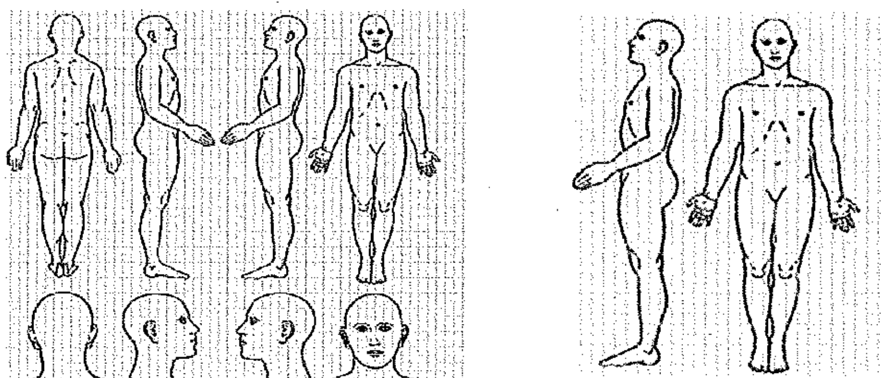
List the extent of your injuries as you know them: ___________________________________

____

____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Please mark an "X" where you feel pain, and an ↓ if it radiates to other parts of your body.



Check symptoms you have noticed since the accident:

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

Patient's Name ______ Date of Birth ______ ID#: ______

Symptoms other than above: ______

______

Where were you taken after the accident? ______

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: ______

Name of Doctor(s): ______

What treatment was given? ______

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? ______ D.C., M.D., D.O., D.D.S.

What was the diagnosis? ______

What treatment was given? ______

How often did you see the doctor? ______

How long did you see the doctor? ______

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? ______

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ... ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name ______ Insurance Company ______ Policy No. ______

Driver of vehicle in which you were injured (if applicable):

Name ______ Insurance Company ______ Policy No. ______

Name of your insurance adjustor ______

Claim #______ Adjuster, name, Company, Phone Number______

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address______

Patient's Name	Date of Birth	ID#:

You were heading North/ East/ South/ West on ______________________________ (street or highway)

Other vehicle was heading North/ East/ South/ West on ______________________________ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? ______________________________

You were struck from Behind/ Front/ Left Side/ Right Side ______________________________

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts ______________________________

Patient Signature ______________________________ Date ______________

Doctor Signature ______________________________ Date ______________

Authorization for Release of Records & Physician's Lien

This form (or a suitable "Letter of Protection" from the attorney) must be executed by the patient, and/or the patient's Attorney, or the insurance company before this clinic will consider awaiting settlement for payment of services rendered in this case.

To:

FROM: CTC CHIROPRACTIC,
Dr. Cornell Cornish Sr, D.C,
1120 E. Pleasant Run Rd., Suite 400, DeSoto, TX 75115

RE: PATIENT RECORDS RELEASE AND DOCTOR'S LIEN

Ref Patient Name:____ Ref #: ____________

RELEASE OF RECORDS: I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his or her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident /illness which occurred/began on__________________________(date of accident or injury).

LIEN ON SETTLEMENT: I hereby give a Lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident / illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing my doctor for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

ASSIGNMENT OF BENEFITS: I further assign my claim or right to compensation for treatment expenses incurred with the doctor/clinic named above arising from a tort or liability claim in connection with this accident or injury.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I understand that I am directly and fully responsible to said doctor/clinic for chiropractic bills submitted by him or her for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.
A photocopy or facsimile of this executed instrument shall be considered as valid as the original.

Patient Signature:____________________________________Dated: ________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named doctor/clinic as per SCR 20:1.15(b). In additional consideration to the above, for executing this lien, the doctor/clinic will provide the attorney or insurance company with billing summaries and availability to discuss the patient's care on a reasonable basis. The attorney may further protect his or her lien interest for compensation by having a priority status over this lien.

Auth. Signature:______________________________________Dated: ________________

NOTICE: Please date, sign, and return the original to our office as soon as possible.
CTC Chiropractic

Dr. Cornell Cornish Sr, D.C,

1120 E. Pleasant Run Rd., Suite 400, DeSoto, TX 75115