YOUNGSVILLE CHIRO & REHAB CENTER AUTO INJURY QUESTIONAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS....THANK YOU)

LAST NAME:_____ FIRST NAME:_____ MIDDLE:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

MAILING ADDRESS (IF DIFFERENT):_____

AGE:_____ DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

SEX: MALE FEMALE # OF CHILDREN:_____ MARRIED SINGLE WIDOWED DIVORCED

OCCUPATION:_____EMPLOYER:_____

SPOUSE:_____ OCCUPATION:_____ EMPLOYER:_____

IN CASE OF EMERGENCY, PLEASE CONTACT (INCLUDE PHONE):_____

DRIVERS LICENSE #:_____ STATE:_____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR YOUR ACCIDENT: YES NO

IF YES, WHO? (NAME & ADDRESS):_____

CHIEF COMPLAINT:

1. Describe your current complaint that you are requesting evaluation and treatment for from this office. Please check the symptoms you have had since the accident:_____

☐ Headaches	☐ Numbness in toes	☐ Loss of Memory	☐ Pain Behind Eyes
☐ Neck Pain/Stiffness	☐ Arm/Leg Weakness	☐ Dizziness	☐ Clicking/Popping Jaw
☐ Mid Back Pain	☐ Sleeping Problems	☐ Numbness in Fingers	☐ Facial Pain
☐ Low Back Pain	☐ Eyes Light Sensitive	☐ Fainting	☐ Irritability
☐ Arm Pain	☐ Fatigue	☐ Breath Shortness	☐ Loss of Balance
☐ Leg Pain	☐ Depression	☐ Ringing/Buzzing	☐ Cold Feet
☐ Muscle Spasm/Cramping	☐ Cold Hands	☐ Chest Pain	
☐ Pain across Shoulder Blades	☐ Diarrhea	☐ Constipation	

HISTORY:

2. What was the Date of the Accident? _____ Time: _____ AM/PM
3. Where were you seated in the vehicle? _____
4. Year & Model of your Car? _____
5. Year & Model of other Car? _____
6. Type of Accident: ☐ Head-on collision ☐ Broad-side Collision ☐ Front Impact ☐ Rear-end car in front of you ☐ Rear Impact ☐ Non-collision
7. Please describe the accident in your own words (be as specific as possible): _____
_____
_____
8. Was your Car moving at the time of the accident? Yes No
   If yes, how fast would you estimate you were going? _____mph
9. Head/body position at time of impact:
   ☐ Head turned left ☐ Head turned right ☐ Body straight in sitting position
   ☐ Head looking back ☐ Body rotated right ☐ Body rotated left
   ☐ Head straight forward Other: _____
10. How fast do you estimate the other car was going?_____mph.
11. Were you wearing your seatbelt? Yes No Did you see the accident coming? YES NO
12. Did you brace yourself for impact? Yes No
13. Upon impact, do you recall striking any objects inside of the car? Yes NO

If yes, what objects did you strike? _____

14. Please describe what symptoms you felt:
Immediately after the accident: _____
Later that day: _____
The next day: _____
15. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
Where have you been treated for this injury prior to presenting to the office? _____
How did you get there? ☐ Ambulance ☐ Police ☐ I drove own car ☐ Someone else drove me ☐ Other: _____
16. Who was the first Doctor that treated you?
Name: _____
Date seen: _____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No Were you: ☐ Standing ☐ Sitting
Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
17. Since the accident, are conditions becoming: ☐ Better ☐ Worse ☐ Same
18. Describe your symptoms: ☐ Constant ☐ Comes & Goes
19. What relieves your symptoms? _____
20. What aggravates your symptoms? _____
21. Road conditions at time of the accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark Other: _____
23. Where was your car struck? _____
24. Were you wearing a hat or glasses? ☐ Yes ☐ No If yes, where were they located after the accident? _____
25. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
26. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
27. As a result of the accident, were you: Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _____
28. What medications are you currently taking? _____

PAST MEDICAL HISTORY

29. Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No
If yes, please explain: _____
30. Have you ever had any prior automobile accidents or ever had any serious falls/injuries? ☐ Yes ☐ No
If yes, please explain: _____
31. Have you ever had any surgeries or been hospitalized overnight? ☐ Yes ☐ No
If yes, please explain: _____
32. Are you currently under the care of any other doctors for any health related concerns? ☐ Yes ☐ No
If yes, please explain: _____
33. Have you ever seen a chiropractor before? ☐ Yes ☐ No
If yes, who, where and what you were treated for: _____

FAMILY HISTORY Please check if any family member has suffered from:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Allergy	☐ Arthritis
☐ High Blood Pressure	☐ Cancer	☐ Migraines
☐ Heart Attacks	☐ Other, list: _____	

35. Who is your family physician for checkups? _____
Date last seen? _____ for? _____
Are you pregnant? ☐ Yes ☐ No

I hereby authorize Youngsville Chiropractic & Rehab Center to examine me, including x-rays if indicated by exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by my findings, and wish all my chiropractic records to be held in strict confidence and not to be given to anyone without written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should the insurance company deny payment, or make payment directly to me.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO YOUNGSVILLE CHIROPRACTIC & REHAB CENTER FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND NO OTHER PURPOSE.

_____ _____
NAME OF PATIENT DATE

_____ _____
SIGNATURE OF PATIENT/GUARDIAN AUTHORIZING CARE DATE

YOUNGSVILLE CHIROPRACTIC CENTER
700 HWY. 1, SUITE 400
YOUNGSVILLE, NC 27596
919-556-2001/919-556-2207

ASSIGNMENT OF PROCEEDS, LIEN AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect to be obligated to pay, provide, or distribute benefits to me for any medical conditions, accident, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of Youngsville Chiropractic Center ("YCC" or "office") such sums as may be owing to YCC for charges incurred by me at the Office relating to my condition ("charges"), with such payments to be made exclusively in the name of Youngsville Chiropractic Center. I further grant a lien to YCC with respect to my charges. This lien shall apply to all payers and the full extent permitted by law. For purposes of this document (herein "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this Office.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to YCC any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers, I hereby authorize YCC to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize YCC to apply any credit balances incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges being related to my condition.

I understand that I remain personally responsible for the total amounts due YCC and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Youngsville Chiropractic Center hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Youngsville Chiropractic Center hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Youngsville Chiropractic Center agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

YOUNGSVILLE CHIROPRACTIC CENTER
BY: _____

Patient Name Printed: _____

Signature: _____ Date: _____

Custodial Parent or Legal Guardian: _____

Parent/Guardian Signature: _____ Date: _____

YOUNGSVILLE CHIROPRACTIC & REHAB
700 HWY. 1, SUITE 400
YOUNGSVILLE, NC 27596
(919)556-2001

OUR OFFICE POLICY

RE: PERSONAL INJURY

If you have been involved in an auto accident, or related injury, and have insurance that covers medical expenses at 100% or an attorney representing you, we will be glad to accept your case with the following regulations:

1. If you have an attorney, notify them as soon as possible and ask him/her to send us a letter of representation. All bills will be sent to the attorney for you. It is our policy to have this information within 5 working days from your initial presentation to our office.

2. If you do not have an attorney you will need to ask the insurance adjuster handling your claim to contact our office and provide all information for billing the insurance company. NO BILLS, OR COPIES OF BILLS WILL BE GIVEN TO YOU OR THE INSURANCE COMPANY UNTIL YOUR ADJUSTER HAS CALLED US AND GIVEN US AN INDICATION THAT THEY WILL DO EVERYTHING POSSIBLE TO PROTECT THE DOCTOR'S INTEREST.

Once your case has settled and all Chiropractic bills have been paid, if an overpayment exists on your account (due to having more than one insurance) we will forward that overpayment to you.

By signing below I am stating that I have read the above and do understand I will not be presented with copies of bills until the proper procedures have been followed.

Sign_____ Date_____

Witness_____ Date_____