KentHagan
ChiropracticInc.

PERSONAL INJURY QUESTIONNAIRE

Patient Information:

Name_____Phone ( )_____

Address_____City_____State_____Zip _____

Age_____ Birthdate_____ Sex_____ SSN #_____

Health Insurance Information:

Insurance Co._____ Member ID #_____

Policy Holder's Name_____ Group # _____

Your Auto Ins. Information:

Insurance Co._____ Policy #_____

Adjustor's Name_____ Claim #_____

Other Party's Auto Insurance Information:

Name_____ Policy #_____

Insurance Co._____ Claim #_____

ATTORNEY Name _____ Phone ( ) _____

Address _____ City_____State _____ Zip _____

ACCIDENT INFORMATION:

Date of Accident _____ Time of Day _____

Were you: ☐**Driver** ☐**Passenger** ☐**Front Seat** ☐**Back Seat** ☐**Pedestrian**

Were there any witnesses? ☐**YES** ☐**NO** **Name(s)** _____

Were you struck from: ☐**Behind** ☐**Front** ☐**Left** ☐**Right**

What did your vehicle impact? ☐**Another vehicle** ☐**Other** _____

Approximate speed of your car_____ mph. Other car_____ mph

Were you knocked unconscious? ☐**YES** ☐**NO** If yes, for how long? _____

Were police notified? ☐**YES** ☐**NO**

In your own words, describe accident:

_____

_____

_____

Please describe how you FELT:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

POST-INJURY INFORMATION:

Have you seen any other doctor(s) since the accident? ☐**YES** ☐**NO**

Name and Address _____

When did you go? ☐**IMMEDIATELY** ☐**NEXT DAY** ☐**2 DAYS PLUS**

How did you get there? ☐**AMBULANCE** ☐**PRIVATE TRANSPORTATION**

Please describe any treatment you received _____

Were **X-Rays** done? ☐**YES** ☐**NO** An **MRI**? ☐**YES** ☐**NO** **CT scan**? ☐**YES** ☐**NO**

Was medication prescribed? ☐**YES** ☐**NO** If yes, what? _____

Indicate symptoms you have noticed:

☐Dizziness	☐Jaw Problems	☐Arm/Shoulder Pain	☐Leg Pain	☐Diarrhea
☐Memory Loss	☐Nausea	☐Numb Hands/Fingers	☐Numb Feet/Toes	☐Difficulty Sleeping
☐Headache(s)	☐Head Seems Too Heavy	☐Neck Pain	☐Chest Pain	☐Irritability
☐Blurred Vision	☐Lights Bother Eyes	☐Mid-Back Pain	☐Short Breath	☐Fatigue
☐Ears Ringing	☐Loss of Balance	☐Low Back Pain	☐Stomach Upset	

☐ **OTHER** _____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ **YES** ☐ **NO**

If yes, please describe in detail _____

Has your condition ☐**IMPROVED** ☐**WORSENED** or ☐**STAYED SAME** since the accident?

Other PRESENT complaints and symptoms? _____

_____

Is your condition affecting your ☐**WORK** ☐**SLEEP** **or** ☐**DAILY ROUTINE?** Please explain.

_____

EMPLOYMENT:

Employer's Name _____ Employer's Address _____

Have you lost time from work as a result of this accident? ☐**YES** ☐**NO** If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? ☐**YES** ☐**NO** If yes, please state type of compensation you are receiving: _____

HEALTH HISTORY

Have you ever had any of the following diseases or conditions?

☐Heart Attack or Stroke	☐Cancer	☐Sinus Problems	☐Difficulty Breathing	☐Anemia
☐Congenital Heart Defect	☐Fainting/Seizure/Epilepsy	☐Shingles	☐Heart Murmur	☐Asthma
☐HIV+/Aids	☐Diabetes	☐Emphysema	☐Hepatitis	☐Ulcers/Colitis
☐High/Low Blood Pressure	☐Artificial Bones/Joints	☐Kidney Problems	☐Heart Surgery or Pacemaker	☐Rheumatic Fever

Please list any other medical conditions that you have or have ever had.

_____

Please list any allergies. _____

Do you smoke? ☐ YES ☐NO How much? _____ How long? _____

For *women*: Are you taking birth control? ☐YES ☐NO

Are you pregnant? ☐YES ☐NO How long?_____ Nursing? ☐YES ☐NO

Please list previous surgeries and dates. _____

_____

Please list any past motor vehicle accidents or traumas and dates. _____

_____

Is there anything else about your health history or family health history that you feel is important to share?

_____

_____

Other pertinent information:

_____

_____

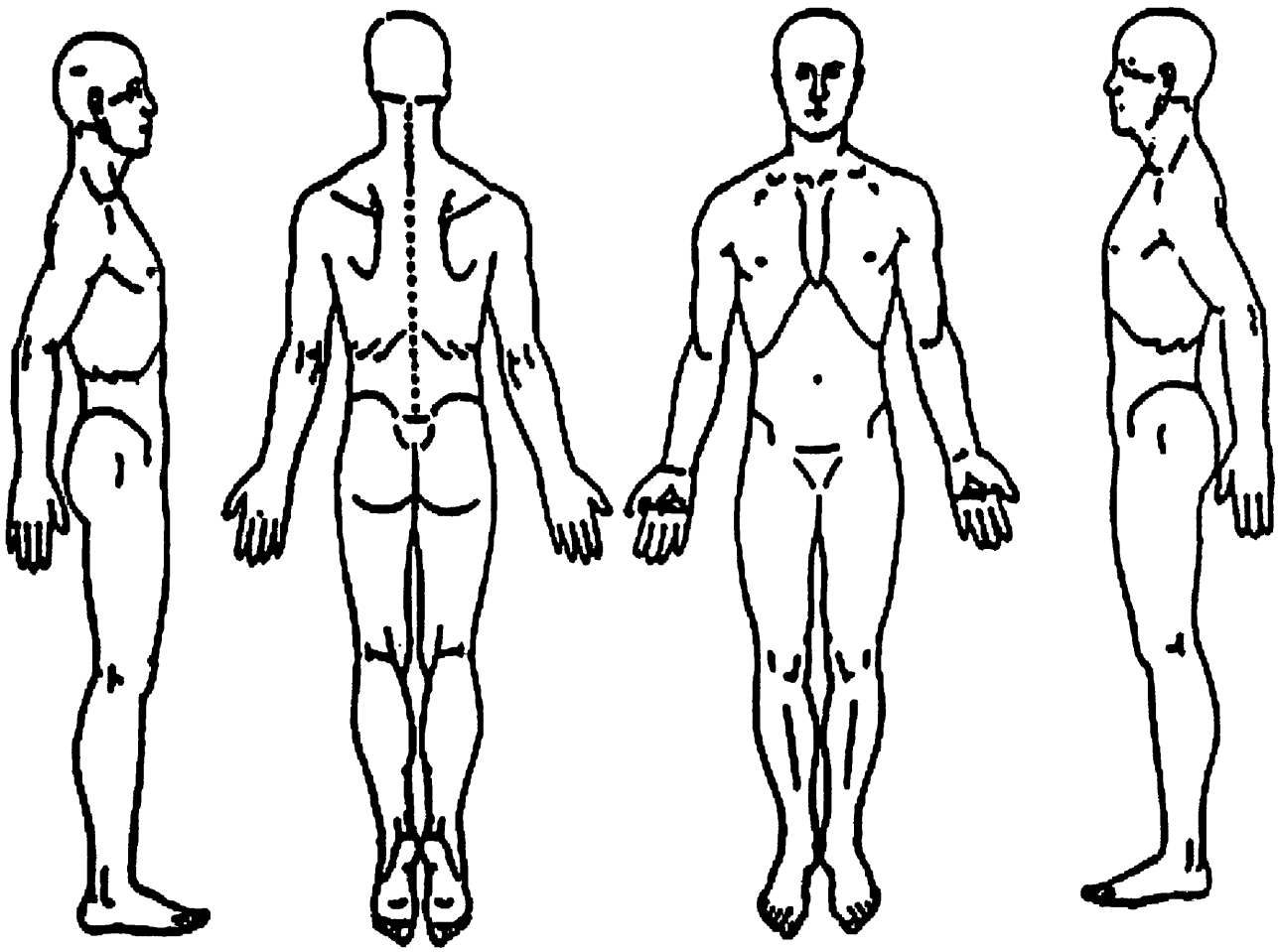
_____ _____

PATIENT'S SIGNATURE **DATE**

Dr. Kent Hagan, D.C. Dr. Jennifer Gong, D.C. Dr. Don Ehasz, D.C.

Name _____ **Date** _____

On the diagram below, please indicate where you are CURRENTLY experiencing pain or other symptoms.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER

HAGAN CHIROPRACTIC & ASSOCIATES

95 Jackson Street
Hayward, CA 94544
Telephone: (510) 581-5813

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue, which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name

_____

Witness Signature

_____

Date

FINANCIAL AGREEMENT PERSONAL INJURY

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your injury. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Party Responsibility
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of *your* automobile insurance policy to cover the treatment charges incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
3rd Party: If another vehicle has caused the accident, we will first bill your automobile Med Pay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault. If we rely solely on a 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement. ***By signing this form, you are agreeing to pay your balance in full within 3 days of receiving your settlement.*** x_____ (Patient's Initials)

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

Attorney Liens
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____
Patient's Signature **Date**

_____ _____
Patient's Name Printed **Witness' Signature**