PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
SSN: _____ Work Phone: _____
Birthdate: _____ Age: _____ Sex: M F Marital Status: S M D W
Occupation: _____ Employer: _____
Responsible Party's Name: _____
Ins. Co. Name: _____ Ins. Phone: _____
Policy Holder's Name: _____ Policy # _____

Attorney Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Were there any witnesses? Y N Name(s): _____

ABOUT THE ACCIDENT:

1. Date of the accident: _____ Time of Day: _____
2. Were you: Driver or Passenger ? Front Seat or Back Seat ?
3. Number of people in your vehicle? _____ Were you wearing seatbelts? Yes No
4. What direction were you headed? North South East West on what street? _____
5. What direction was the other vehicle headed? North South East West on what street? _____
6. Were you struck from: Behind Front Left Side Right Side ?
7. Approximate speed of your car: _____mph Of the other car: _____mph
8. Were you knocked unconscious? Yes No If yes, for how long? _____
9. Were police notified? Yes No If yes, please obtain a police report for our file.
10. In your own words, please describe the accident: _____
11. Did you have any 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 the accident: _____
    c) LATER THAT DAY: _____
    d) THE NEXT DAY: _____
13. What are your PRESENT complaints and symptoms? _____
14. Do you have any congenital (from birth) factors which relate to this problem? Yes No
    If yes, please describe: _____
15. Do you have any previous illnesses which relate to this case? Yes No If yes, please describe: _____

16. Have you ever been involved in an accident before? Yes No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

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 phone: _____

What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms: Improving Getting Worse Same ?

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 Stiff	___ Dizziness	___ Fatigue	___ Loss of Balance	___ Fainting
___ Lights Bother Eyes		___ Stomach upset	___ Constipation	___ Fever
___ Sleeping Problems	___ Head Seems too Heavy		___ Cold Sweats	___ Depression
___ Loss of Smell	___ Loss of Taste		___ Nervousness	___ Back Pain
___ Pins, Needles in Arms	___ Pins, Needles in Legs		___ Loss of Memory	___ Tension
___ Numbness in Fingers	___ Ringing in Ears		___ Diarrhea	

Symptoms other than above: _____

21. Have you lost time from work as a result of this accident? Yes No If yes, please complete these questions: a) Last day worked? _____

b) Type of employment? _____

c) Present salary? _____

d) Are you being compensated for time lost from work? Yes No

If yes, please state type of compensation: _____

22. Do you notice any activity restrictions as a result of this injury? Yes No If yes, please describe in detail: _____

_____

23. Other pertinent information: _____

_____

_____

_____

I clearly understand and agree to all services rendered to me and that I remain personally responsible for payment. In the event that (a) my insurance coverage has lapsed, been exhausted, or is non-existent; or (b) my contract with my attorney is terminated; any fees for professional services rendered to me will be immediately due and payable. If this office must take any action to collect an outstanding balance on my account, I will be responsible for reimbursing Duchon Chiropractic for all costs of such collection efforts.

Signature _____ **Date** _____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, **Duchon Chiropractic Clinic (DCC)**, such sums as may be owing to **DCC** for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to **DCC** with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be construed as election by **DCC** to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **DCC**, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to **DCC** to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my nave or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, 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 expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide full Accounting of such funds to the Office upon its request.

I hereby direct all payers to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **DCC** to endorse/sign my nave on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due **DCC** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **DCC** for all costs of such collection efforts, including, but not limited to, all court cost and all attorney fees.

This agreement shall not be modified or revoked without mutual written consent of **DCC** 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 Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **DCC** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any part here to, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): _____

Patient Signature: _____ Date_____

Name of Custodial Parent or Legal Guardian (please print)_____

Parent/Guardian's Signature:_____ Date_____

Duchon Chiropractic

Authorization for Release of Information

Patient Name: _____ DOB: ___/___/___ SSN: ___-___-____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

I authorize: _____

Physician Name Facility Name Facility Phone

_____

Facility Address Facility Fax

To send/release photocopies of medical records concerning the above named person to:

Duchon Chiropractic
2724 61st #5
Galveston, Texas 77551

For the purpose of treatment for _____. I authorize the release of photocopies of the following medical records and information in their possession including all confidential HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis and treatment information. I agree that these provisions will remain in effect until I provide written revocation to Duchon Chiropractic.

☐ Medical Records ☐ Hospital Records ☐ Procedure Records ☐ Laboratory Records

_____ Inpatient _____ Outpatient ☐ Other

_____ _____ _____

Signature of Patient/Legal Guardian Relationship to Patient Date

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AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payers, and I authorize Duchon Chiropractic to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Duchon Chiropractic.

I agree that these provisions will remain in effect until I provide written revocation to Duchon Chiropractic.

_____ _____ _____

Signature of Patient/Legal Guardian Relationship to Patient Date

2724 61st #5
Galveston, Texas 77551
Office: 409-744-9355 • Fax: 409-744-9356

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Other _____
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Reviewed by Provider:_____(initials)

Galveston Physical Medicine

2724 61st #5

Galveston, Texas 77551

Office 409-744-9355 Fax 409-744-9356

X-ray Questionnaire: For Women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-ray be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because:_____

_____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date