PERSONAL INJURY QUESTIONNAIRE

FULL NAME _____ PHONE _____
ADDRESS _____CITY _____ ZIP _____
AGE _____ BIRTH DATE _____ SEX _____ SS# _____-_____-_____
SPOUSE'S NAME _____ BIRTH DATE _____
Employer _____ Employer Address _____
Employer Phone # _____ Occupation _____

YOUR AUTO INSURANCE INFORMATION:

Name of Insured _____ Policy # _____
Insurance Company _____ Phone # _____
Address _____ City _____ Zip _____
PLEASE GIVE US A COPY OF THE COVERAGE PAGE OF YOUR AUTO POLICY.

THE AUTO INSURANCE OF THE OTHER PARTY INVOLVED:

Name of Insured _____ Policy # _____
Insurance Company _____ Phone # _____
Address _____ City _____ Zip _____
Adjuster _____ Claim # _____

YOUR HEALTH INSURANCE INFORMATION:

Name of Insured _____ Relationship to You _____
Insurance Company _____
Group Plan # _____ Phone # _____
Insured SS# _____-_____-_____ Dependents _____
PLEASE GIVE US A COPY OF YOUR INSURANCE ID CARD.

ATTORNEY INFORMATION (IF APPLICABLE):

Attorney Name _____ Phone # _____
Address _____ City _____ Zip _____

ACCIDENT INFORMATION: In your own words, please describe the accident in detail.

_____
_____
_____
_____
_____
_____
_____

Please use the back to write additional information or to draw a diagram.

Date of Accident _____ Time of Day _____ am/pm

PERSONAL QUESTIONNAIRE, Page 2

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
How many passengers were in the car with you? _____
Was there a Police Report? ( ) Yes ( ) No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

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

Symptoms Other Than Above _____

Did you receive any other medical/chiropractic care directly after the accident: ( ) Yes ( ) No
If yes, please describe: _____

_____

_____

Please describe your PRESENT symptoms and complaints: _____

_____

_____

_____

Since the car accident, have your symptoms:
( ) improved ( ) stayed the same ( ) gotten worse

Do you notice restrictions in any other area of your life as a result of this accident?

_____

_____

Have you lost any time from work as a result of the accident? ( ) Yes ( ) No

Did you have any physical complaints before the accident? ( ) Yes ( ) No
If yes, please describe: _____

_____

Other pertinent information: _____

_____

_____

Signed _____ **Date** _____

Legal Guardian (if applicable) _____ **Date** _____

ASSIGNMENT, LIEN, AND INSTRUCTIONS FOR PAYMENT TO
ADJUSTING THE WORLD CHIROPRACTIC

I hereby instruct and direct _____to send my payment directly to:

Adjusting the World Chiropractic
16419-C Northcross Drive
Huntersville, NC 28078

For professional or medical expenses benefits allowable and otherwise payable to me, under my Current Medical Payment Policy or known as Med-Pay Policy or other Liable Carriers as payment towards the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assigned/lien holder, and I have agreed to pay, in a current manner, any balances of said professional services over and above the insurance, liable party or Med-Payment according to the financial policy of the above assignee/lien holder.

This authorization for DIRECT PAYMENT to Adjusting the World Chiropractic shall supersede all prior/future written authorizations including any assignment/authorization given by me, to any legal counsel representing our interest. I also authorize the release of any information pertaining to my case to any insurance company, adjuster, or attorney involved in this case. This authorization shall remain enforceable in accordance with North Carolina general statutes 44-49 and 44-50.

A photocopy of this assignment/lien shall be considered as effective and valid as the original.

Date:____/____/_____

Patient:(print)_____

Patient/Guardian's signature_____

Signature of Witness_____

INSURANCE COMPANY ONLY

Please confirm your receipt of this lien by signing below and returning a signed copy for our patient(s) records. Thank you.

Signature _____ Date _____

Print Name _____ Title _____