Automobile Accident Questionnaire

Please answer all questions completely

Name:_____ Sex:____ Marital Status:_____ Date of Birth: _____ Home Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____

(indicate if child, student, housewife, unemployed, retired)

Social Sec #:_____ Business Phone:_____ Company Name:_____
Location:_____

Spouse's First Name:_____ Spouse's Soc Sec #_____ Spouse's Employer:_____
Location:_____

Please explain in detail how your accident happened

_____
_____
_____
_____

You were heading ☐North ☐East ☐South ☐West on_____ (street or highway)

Other vehicle was headed ☐North ☐East ☐South ☐West on_____ (street or highway)

Were police notified? ☐Yes ☐No

Did an ambulance arrive? ☐Yes ☐No If yes, were you transported to a hospital? ☐Yes ☐No

Were you knock unconscious? ☐Yes ☐No If so, for long?_____

You were struck from ☐Behind ☐Front ☐Driver side ☐Passenger side

Did you hit your ☐head ☐shoulder or ☐ knee on any objects in the car?

Did any of your air bags opened? ☐Yes ☐No

Did you sustained any ☐bruising ☐burns or ☐ cuts

You were ☐ Driver ☐Passenger ☐Front seat ☐Back seat ☐Using seat belts ☐Other protective devices

What was the date of your accident?_____

Where did you feel pain immediately after the accident?_____

Did you go to a hospital or a walking urgent care?_____

What treatment was given?_____

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

What treatment was given?_____

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

Did you lose any days from work due to your accident?_____

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

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

Name _____ Social Security No. _____
(last) (first) (middle)

Address _____ City _____ Zip _____ Phone _____

Birth date _____ Age _____ ☐ Male ☐ Female No. of children _____

Occupation _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employed by _____ Business Phone _____

Address _____ City _____ State _____ Zip _____

Name of spouse (or parent, if minor) _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Person responsible for account _____

Address _____ City _____ State _____ Zip _____

Referred by _____

Have you had chiropractic care before? _____ When? _____

Do you have health insurance? _____

Address _____ Policy Number _____

Date of Last Physical Examination _____

What Operations Have You Had? _____ When? _____

Serious Illnesses? _____ When? _____

Date Called _____
C.A. Accepting _____
Appt. _____
Complaint _____
How long _____
B.C. _____
B.C.B.S. _____
Insurance _____
PIP _____
W.C. _____

FAMILY HISTORY OF:

YES	NO	
☐	☐	Diabetes
☐	☐	Heart Disease
☐	☐	Cancer
☐	☐	Kidney Dis.
☐	☐	Arthritis

Have You Ever Suffered From:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Dizziness	☐	☐	Headaches	☐	☐	Nervousness	☐	☐	Fatigue
☐	☐	Backaches	☐	☐	Numbness	☐	☐	Sinus Trouble	☐	☐	Indigestion
☐	☐	Heart Trouble	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Fainting
☐	☐	Diabetes	☐	☐	Neuritis	☐	☐	Rheumatic Fever	☐	☐	Constipation
☐	☐	Tuberculosis	☐	☐	Digestive Disorders	☐	☐	Cancer	☐	☐	Insomnia
☐	☐	Sexual Impotency	☐	☐	Swelling Joints	☐	☐	Vision Problems	☐	☐	Hot Flashes
☐	☐	Arthritis	☐	☐	Excessive Gas	☐	☐	Labored Breathing	☐	☐	_____

Purpose of this Appointment _____

Other Doctors Seen For This Condition _____

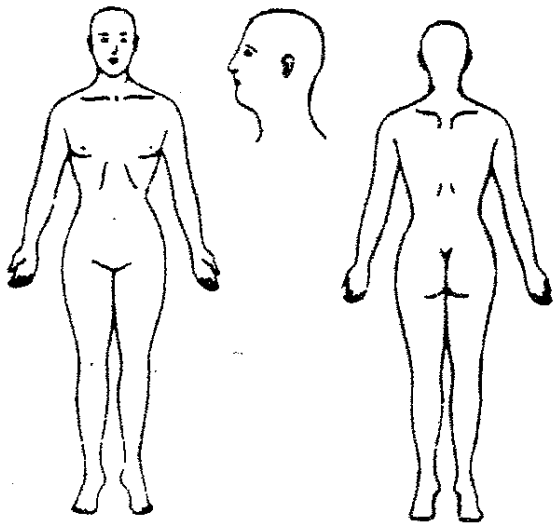
Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe _____

What medications or drugs are you taking? _____

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that for all services rendered to me I am personally responsible for payment. **I hereby assign my insurance benefits to be paid directly to** DR. GLEN D. BERMAN **and acknowledge that I am financially responsible for NON-COVERED SERVICES. I hereby authorize my physician to release any information required to support my claim.**



Date _____

Patient's Signature _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care).

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition.