Automobile Accident Questionnaire
UNRUH CHIROPRACTIC AND WELLNESS CENTER

Please answer all questions completely.

Today's Date: _____

Name: _____, Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Company Name: _____ Occupation: _____

Company Address: _____

Social Security #: _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ S ☐ M ☐ D ☐ W, Who referred you to our office? _____

Please explain in detail how your accident happened: _____

_____

_____

_____

Your Ins. Company & Contact Name: _____

Your Ins Co Address: _____

Your Insurance Co Phone number: _____ Fax number:_____

Your Ins Co Claim No: _____Do you have Medpay? ☐ Yes ☐ No Amt: $_____

Driver of other vehicle (if any) _____

Other Insurance Company & Contact Name: _____

Other Insurance Co Address: _____

Other Insurance Co Phone number: _____ Fax number:_____

Other Ins Claim No: _____ Date of the Accident/Injury: _____

Time of Accident/Injury: _____ ☐ AM ☐ PM City/State: _____

You were heading ☐ North ☐ South ☐ East ☐ West on _____ (Street/Hwy)

Number of people in your vehicle: _____ Were police notified? ☐ Yes ☐ No If yes, PLEASE BRING A COPY OF THE POLICE REPORT AS SOON AS IT BECOMES AVAILABLE

Did your head strike the windshield or an object? ☐ Yes ☐ No; Loss of Conscious? ☐ Yes ☐ No

If so, how long: _____. From which side were you struck: ☐ Front ☐ Back ☐ Left ☐ Right

Did you see that your vehicle was going to be struck, or were you surprised after your vehicle was struck?

☐ I saw that the vehicle was going to be struck ☐ I was surprised after the vehicle was struck

Were you: ☐ Driver ☐ Passenger, ☐ Front Seat ☐ Back Seat, ☐ Using Seat Belts ☐ Using other protective devices. Did you feel immediate pain? ☐ Yes ☐ No ☐ Later that day ☐ Next Day

When & Where did you first feel pain? _____

Describe immediate treatment given: _____

Was any doctor consulted after the accident? ☐ Yes ☐ No

If so, Doctor's Name: _____ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S. ☐ _____

Doctor's Diagnosis: _____

What treatment was given? _____

How often did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what complaints: _____

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

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

Since the injury, are your symptoms ☐ Improved? ☐ Getting worse? ☐ The same?

Have you retained an attorney? ☐ Yes ☐ No ☐ Not Yet

If so, name, address & phone: _____

FINANCIAL POLICY……..AUTO ACCIDENT

Charges incurred for your care are filed to your auto insurance medical benefits. **This does not increase your premiums!** They in turn will collect from the insurance of the responsible party.

If you do not have medical benefits on your insurance policy, Unruh Chiropractic & Wellness Center requires that you retain an attorney. That attorney will be expected to handle your financial responsibilities to this office. We recommend that you attain Ken Swindle from Swindle Law Firm, his phone number is (479) 621-0120. A "physician's lien" will likely be filed to insure your account here is settled.

If your account is not settled in-full 90 days after the completion of your treatment, YOU ARE REQUIRED TO BEGIN MAKING MONTHLY PAYMENTS of 5% (five percent of total account balance) toward your account.

I have read and understand the financial policy of Unruh Chiropractic & Wellness Center.

_____

Name (print) **Signature (required)** **Date**

Office Use Only Financial policy reviewed by: (C.A. Initials) Date: / /

Application For Admission
UNRUH CHIROPRACTIC AND WELLNESS CENTER

Today's Date _____

Name _____ Age _____

Address_____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

email_____ Birthday _____ Sex: ☐ M ☐ F

Social Security _____ Best place to reach you: ☐ Home ☐ Work ☐ Cell

May we leave a voice mail message for you? ☐ Yes ☐ No Occupation_____

Employer name _____ Length of Employ_____

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse's Name _____

Spouse's SS#_____ Names and Ages of Children_____

_____

IF THE PATIENT IS A MINOR, parents name _____

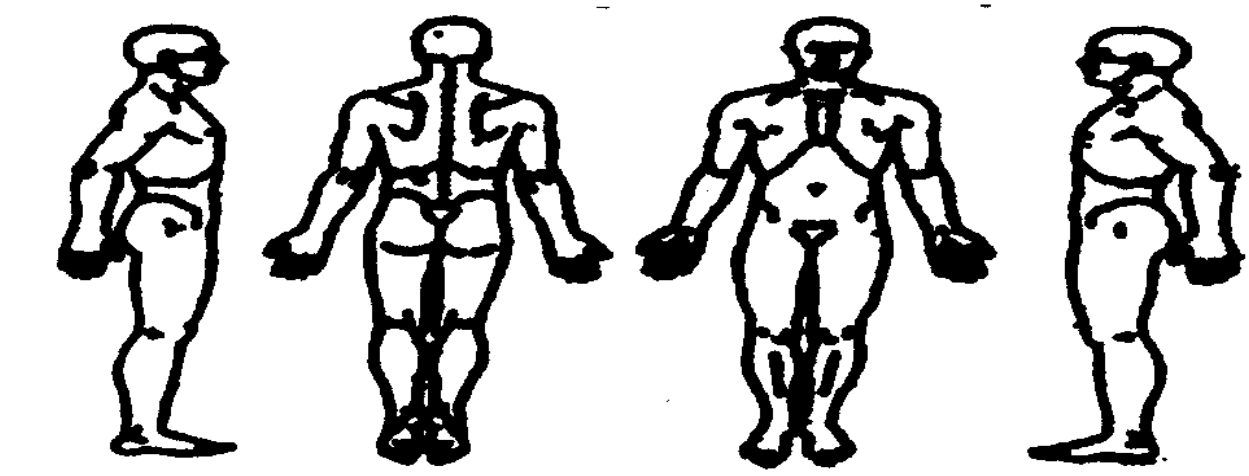
If your insurance doesn't cover your care are you willing to pay out of pocket?

☐ **Yes** ☐ **No**

How Did You First Hear About Unruh Chiropractic and Wellness Center?

_____

1. Is today's problem caused by ☐ Auto Accident ☐ Work Injury ☐ Other: _____
2. How do you think your problem began? _____
3. How long have you had this problem? _____
4. Indicate on the drawings below where you have pain/symptoms.



5. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (25-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

6. How would you describe the type of pain?

☐ Sharp ☐ Shooting ☐ Shooting with motion
☐ Dull ☐ Stiff ☐ Stabbing with motion
☐ Diffuse ☐ Numb ☐ Electric-like with motion
☐ Achy ☐ Tingly ☐ Other:_____
☐ Burning ☐ Sharp with motion

7. How are your symptoms changing with time?

☐ Getting worse ☐ Staying the same ☐ Getting better

8. Using a scale from 0-10 (10 being the worst), how would you rate your problem? _____

9. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

10. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

11. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other:
☐ Massage Therapist ☐ Physical Therapist ☐ No one

12. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height:_____ Weight:_____ Age: _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

19. List all of the medications you are currently taking: _____

_____

20. List all of the over-the-counter medications you are currently taking: _____

_____

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Now" column:

Past	Now	Condition	Past	Now	Condition	Past	Now	Condition
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis, Eczema, Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Muscular Incoordination
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Visual Disturbances
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Abnormal Weight Gain / Loss
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	General Fatigue
☐	☐	Cancer	☐	☐	Asthma	For Women Only:		
☐	☐	Tumor	☐	☐	Chronic Sinusitis	☐	☐	Birth Control Pills
☐	☐	Other: _____				☐	☐	Hormonal Replacement
						☐	☐	Pregnancy

22. List all of the surgical procedures you have had: _____

_____

23. What activities do you do at work?

☐ Sit:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer work:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

24. What activities do you do outside of work? _____

_____

25. Have you ever been hospitalized? ☐ Yes ☐ No If yes, why? _____

_____

26. Have you had significant past trauma? ☐ Yes ☐ No If yes, describe: _____

_____

27. Anything else pertinent to your visit today? _____

_____

_____

Terms of Acceptance & Privacy Policy
UNRUH CHIROPRACTIC AND WELLNESS CENTER

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine and extremities.

Health: a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

_____ Unruh Chiropractic & Wellness Center does not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of the health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ I understand that I am responsible for all costs of incurred in course of my treatment, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ I understand and agree to allow Unruh Chiropractic & Wellness Center to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care and that all my medical records and personal contact information will be kept confidential.

I, _____ (print your name), have read and fully understand the above statements and all of the information I have provided is accurate to the best of my knowledge.

Signature: _____ Date: _____