

CENTER FOR NATURAL HEALTHCARE, PLLC

Providing Steps to Wholeness

Personal Injury Questionnaire

ABOUT YOU

Name: _____
Address: _____

Phone: (H) _____ (W) _____
(C) _____
Age: _____ Birthdate: _____ Sex: M F
Email: _____
Emergency Contact: _____
Emergency Contact Phone: _____
Referred by: _____

ATTORNEY

Do you have an attorney: () Y () N
Name: _____
Address: _____

Phone number: _____

AUTO/PERSONAL INSURANCE

Your Ins. Co. _____
Claims Address: _____

Policy # _____
Name on policy: _____
Agent's Name: _____
Agent's Phone: _____
Ins. Co. Phone # _____
Claim # _____
Adjuster's Name: _____
Adjuster Phone: _____
Were you responsible for the accident? Y N
If No, what is the responsible party's name?

Address: _____

Policy holder's name: _____
Policy #: _____

NATURE OF THE ACCIDENT

Date of the accident: _____ Time of Day: _____ ☐ AM ☐ PM
City and State in which the accident occurred: _____
Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
Were you wearing a seatbelt: ☐ Y ☐ N
In which direction were you headed: ☐ North ☐ East ☐ South ☐ West
Name of Street/Intersection/Highway: _____
Were you struck from: ☐ Behind ☐ Front ☐ Left ☐ Right
Approximate speed of your car: _____ MPH Other car: _____ MPH
Were you knocked unconscious? ☐ Yes ☐ No If Yes, for how long? _____
Were the police notified? ☐ Yes ☐ No
Were there any witnesses? ☐ Yes ☐ No Names: _____
In your own words, please describe the accident: _____

Did you have any physical complaints BEFORE THE ACCIDENT: ☐ Yes ☐ No

If yes, please describe in detail: _____

Please describe how you felt:

- a. DURING the accident: _____
b. IMMEDIATELY AFTER the accident: _____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____

PRIMARY COMPLAINT:

Please list your first/primary complaint/symptom: _____

How often do you feel it? ☐ Constant ☐ Daily ☐ Comes and goes
How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching
☐ Stiff ☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

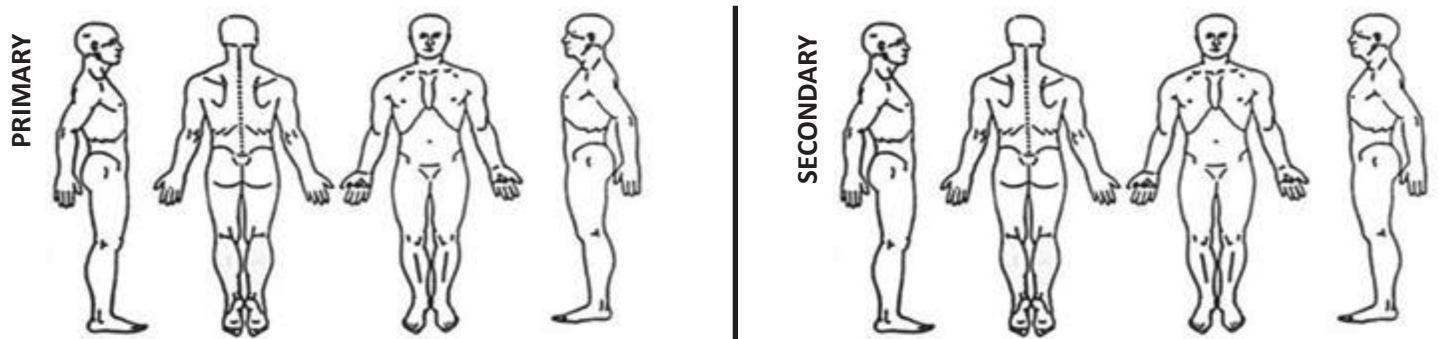
What makes your condition worse? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful/difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving
☐ Other: _____

Please mark where it hurts:



SECONDARY COMPLAINT:

Please list your secondary complaint/symptom: _____

How often do you feel it? ☐ Constant ☐ Daily ☐ Comes and goes
How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching
☐ Stiff ☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful/difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving
☐ Other: _____

Do you have additional symptoms/complaints due to this accident: ☐ Yes ☐ No

If, yes, then please list them on the back of this sheet.

Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No

If Yes, then please describe: _____

Have you had any previous accidents/injuries prior to this accident? ☐ Yes ☐ No

If Yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No

If Yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

Since the injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

CHECK THE 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 the ears | ☐ Hands Cold |
| ☐ Neck Stiff | ☐ Stomach Upset | ☐ Sleeping Problems | ☐ Loss of Balance | ☐ Dizziness |
| ☐ Fatigue | ☐ Depression | ☐ Head Seems Too Heavy | ☐ Fainting | ☐ Constipation |
| ☐ Back Pain | ☐ Cold Sweats | ☐ Pins and needles in arms | ☐ Light bothers eyes | ☐ Loss of smell |
| ☐ Fever | ☐ Loss of Memory | ☐ Pins and Needles in Legs | ☐ Loss of Taste | ☐ Nervousness |
| ☐ Tension | ☐ Ears Ring | ☐ Numbness in Fingers | ☐ Diarrhea | ☐ _____ |

Symptoms other than above: _____

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. Present Salary: _____

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

If Yes, please state type of compensation you are receiving: _____

Did you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If Yes please describe in detail: _____

Other pertinent information: _____

PERSONAL HEALTH INSURANCE INFORMATION:

Insurance Co. Name: _____ Address: _____

Ins. Co. Phone: _____ Insured's Name: _____ S.S.# _____

Insured's D.O.B. _____ Insured's Employer: _____ Policy # _____

OTHER PASSENGERS IN THE CAR:

Were there any other passengers in the car? ☐ Yes ☐ No If Yes, please list:

<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>	<u>Phone Number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

AUTHORIZATION, ASSIGNMENT AND RELEASE FORM:

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute an action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and /or recovery in this State of Minnesota.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

Patient/Insured Signature

Date

ASSIGNMENT OF AUTOMOBILE INSURANCE BENEFITS

I hereby assign and transfer to Center for Natural Healthcare, PLLC any and all causes of action that exist in my favor against any automobile insurance company for personal injury protection or medical payments coverage benefits.

Signature: _____ Date: _____ Witness: _____

RECORDS RELEASE

To _____, I hereby authorize you to release to Center for Natural Healthcare, PLLC any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to _____.

☐ Complete Records ☐ Recent Progress

Notes ☐ X-ray Reports ☐ X-ray Films ☐ Diagnostic Imaging Reports ☐ Lab Reports ☐ Other _____

Patient/Insured Signature

Date

Dr. Joseph H. Sevlie, D.C., FASA
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