

CHIROPRACTIC  
Automobile/PI Accident or Work Comp Questionnaire

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
HR#:

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened:

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What were the time and date of present injury?

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Where did you feel pain immediately after the accident?

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List the extent of your injuries as you know them:

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Did you require post-accident hospitalization?    Yes    No

Check symptoms you have noticed since the accident:



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

Symptoms other than above:

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Where were you taken after the accident?

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Hospitalized? Yes No If yes, admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Hospital:

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Name of Doctor(s):

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What treatment was given?

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Was any other doctor consulted after your accident? Yes No

If so, what was the doctor's name?

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D.C., M.D., D.O., D.D.S.

What was the diagnosis?

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What treatment was given?

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How often did you see the doctor?

\_\_\_\_\_

How long did you see the doctor?

\_\_\_\_\_

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

If so, what were the complaints?

\_\_\_\_\_

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

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

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

Driver of other vehicle (if any):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy No. \_\_\_\_\_

Name of your insurance adjustor

\_\_\_\_\_

Have you retained an attorney? Yes No

If so, his/her name and address \_\_\_\_\_

\_\_\_\_\_

You were heading North/ East/ South/ West on

\_\_\_\_\_ (street or highway)



Other vehicle was heading North/ East/ South/ West on  
\_\_\_\_\_ (street or highway)

Were police notified? Yes No

Were you knocked unconscious? Yes No If yes, for how long?  
\_\_\_\_\_

You were struck from Behind/ Front/ Left Side/ Right Side  
\_\_\_\_\_

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_



ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP,  
ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH  
INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND  
DESIGNATION OF AUTHORIZED REPRESENTATIVE

Provider Name: Lisa Williams, DC  
Clinic: Jubilee Family Chiropractic  
Address: 1770 Timberwood Blvd #103, Charlottesville, VA 22911

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feason insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_