# 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:_____

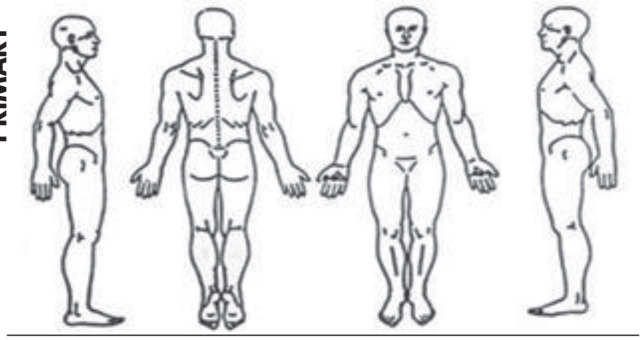
_____

_____

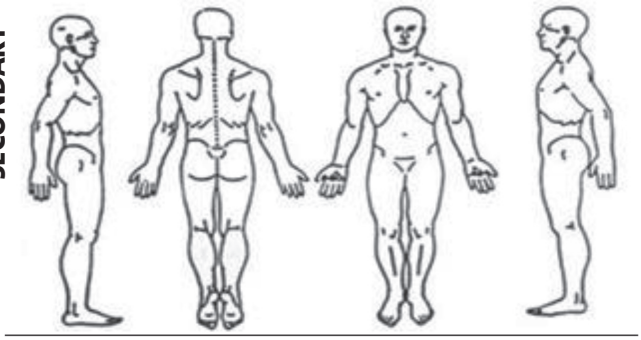
How often do you feel it? ( ) Constant ( ) Daily ( ) Comes and goes
How does it feel? ( ) Burning ( ) Sharp ( ) Shooting ( ) Dull ( ) Aching
( ) Stiff ( ) Tingling ( ) Throbbing ( ) Swelling ( ) Other_____
*Circle below the severity of your pain on a scale of 0 to 10:*
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (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:***

PRIMARY



SECONDARY



## 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 inury(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:

| Name | Age | Relationship to you | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 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 stature 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

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## 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: _____

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## 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

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