Claim #: _____

MYERS CHIROPRACTIC
PERSONAL INJURY QUESTIONAIRE

PERSONAL INFORMATION

Name: _____ Sex: M F Date: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone:

Date of Birth: _____ Soc. Sec. #: _____ Email: _____

Employer: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Care Physician: _____ Telephone #: _____

AUTO INSURANCE INFORMATION

Auto Insurance Company _____ Claim Number: _____

Claims Manager: _____ Telephone: _____Ext. _____

COLLISION INFORMATION

1. Date of collision: _____Time of day: _____ am/pm
2. Road Conditions: _____
3. Location of collision: _____
4. Claim Number: _____

VEHICLE INFORMATION

5. Type and Model of your car:_____
6. Type of the other vehicle: ☐ Motorcycle/Bike ☐ Car ☐ Truck/Van/Semi-Truck

   Make: _____ Model: _____ Year: _____

MECHANISM OF INJURY

7. Were you wearing a seat belt? ☐ No ☐ Yes If yes: ☐ Lap belt ☐ Shoulder belt ☐ Both
8. Were the airbags activated? ☐ No ☐ Yes
9. Was your car stopped or moving at the time of impact? _____
10. Where was the impact on your car? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger side
11. Any bruising or soreness from the seat belt? No Yes If yes, please explain: _____

    _____
12. Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ pedestrian at the time of the accident?

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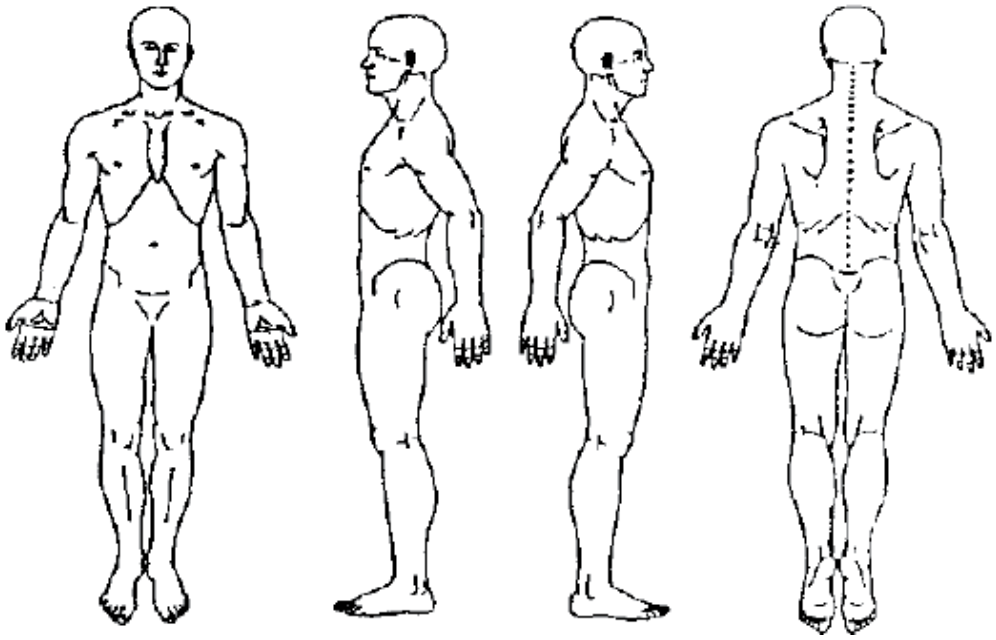
13. **Check the symptoms you have experienced since the collision and that you attribute to the collision.**

☐ Headache	☐ Loss of Memory	☐ Cold hands
☐ Neck pain/stiffness	☐ Fatigue	☐ Cold feet
☐ Low Back Pain	☐ Breath shortness	☐ Diarrhea
☐ Mid back pain	☐ Irritability	☐ Constipation
☐ Eyes Light Sensitive	☐ Depression	☐ Chest Pain
☐ Pain Behind Eyes	☐ Ear Ringing/Buzzing	☐ Nervousness
☐ Arm / Hand Pain	☐ Loss of balance	☐ Cold Sweats
☐ Arm / Hand Numbness	☐ Tension	☐ loss of smell
☐ Leg / Foot Pain	☐ Dizziness	☐ loss of taste
☐ Leg / Foot Numbness	☐ Fainting	
☐ Facial Pain	☐ Sleeping problems	
☐ Clicking or popping jaw	☐ Anxious	

Pain Diagram and Pain Scale

14. **Use the symbols below to represent your symptoms on the diagram to the right:**

A: Achy **B: Burning** **D: Dull** **N: Numb** **S: Sharp** **T: Tingly**



PLACE AN X on the line indicating the level that most accurately represents your pain:

0 – Indicates **NO PAIN**
10 Indicates **EXCRUCIATNG PAIN**

0 1 2 3 4 5 6 7 8 9 10

a) Right Now: _____

b) At Worst: _____

Claim #: _____

15. Have you missed work due to this collision? ☐ yes ☐ no If yes, how much work? _____

_____

16. Did you seek medical help after the collision? ☐ yes ☐ no Doctor's name? _____

Were you given medication? ☐ yes ☐ no Were X-rays taken? ☐ yes ☐ no

17. Since the injuries occurred, symptoms are: ☐ Improving ☐ Getting Worse ☐ No Change

18. Have you ever been involved in a collision before? ☐ No ☐ Yes If yes, describe: (include dates, type of collision, and injuries received)

_____

_____

_____

_____

19. Please describe in your own words how the collision took place. _____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependants or I are entitled to under my auto insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that he/she signs as an agent that is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, shall pay all reasonable collection expenses, interest on unpaid balance at 1% per month from the date of service, and/or reasonable attorney fees and court costs.

Signed: _____ Date: _____

(Patient - Parent or Guardian if under 18 years of age)