Auto Injury Questionnaire

IGNITE CHIROPRACTIC

Your Name_____

Your Phone Number_____

Your Auto Insurance Company_____

Name on policy (if other than yourself)_____

Attorney Information

Name_____Phone__(_____)_____

Address_____City_____State_____Zip_____

Nature of Accident

1. Date of accident_____Time of Day_____
2. Were you in: *Driver seat* *Passenger seat* *Backseat Driver Side* *Backseat Passenger Side* *Middle seat*
3. Did your car have a head rest? *Yes / No*

   If yes, what setting was it at time of accident: *Bottom of neck* *Bottom of head* *Middle of head*
4. Number of people in vehicle_____Were you wearing seatbelts? *Yes / No*
5. Were you struck from: *Behind* *Front* *Driver Side* *Passenger Side*
6. Speed of your vehicle?_____mph Other vehicle_____mph
7. Were you knocked unconscious? *Yes / No* If yes, how long? _____
8. Were police notified? *Yes / No*
9. Kind of car you were driving: Make_____Model_____Year_____
10. How much damage to your car $_____
11. In your own words, please describe the accident: _____

_____

_____

12. Did you have any physical complaints/injuries/problems BEFORE the accident? *Yes / No*
13. Please describe what you felt: During the accident_____

Immediately after the accident _____

Later that day_____The next day_____

14. Where were you taken after the accident_____

    List treatments you received_____
15. What other Dr's have treated you since the accident_____
16. Since the accident, your symptoms are: *Improving* *Getting Worse* *Same*
17. Have you lost time from work as a result of this accident? *Yes / No*

    If yes, explain: _____
18. Have you noticed ANY activity restrictions as a result of this accident? *Yes / No*

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty:

1 ="I can do it without any difficulty" 2 ="I can do it without much difficulty, despite some pain" 3 ="I can manage to do it by myself, despite marked pain"
4 ="I manage to do it, despite the pain, but only if I have help" 5 ="I cannot do it at all because of the pain" *Only i areas affected*.

Difficulties with Self Care and Personal Hygiene Activities

Bathing…….....	_____	Drying hair…….....	_____	Brushing teeth……..….	_____	Putting on shoes.....	_____
Preparing meals……..	_____	Showering……..…..	_____	Combing hair…….....	_____	Making bed…….....	_____
Tying shoes…….	_____	Eating……..….	_____	Doing Laundry……..	_____	Washing hair.…….	_____
Washing face……..	_____	Putting on pants…….	_____	Cleaning dishes…….	_____	Going to toilet…..…	_____

Difficulties with Physical Activities

Standing…….....	_____	Walking……..…....	_____	Kneeling……..…..…...	_____	Reaching…….....	_____
Twisting left …….....	_____	Twisting right…….....	_____	Stooping…….....	_____	Leaning back.….....	_____
Leaning forward…….….....	_____	Leaning left…….....	_____	Leaning right…….....	_____	Bending left….....	_____
Bending right…….....	_____	Bending back……..….	_____	Bending forward…….....	_____	Reclining…….....	_____
Squatting…….....	_____	Sitting for long periods.	_____	Standing for long periods.	_____	Walking for long periods	_____
Kneeling for long periods.....	_____						

Difficulties with Functional Activities

Carrying small objects……..…...	_____	Carrying large objects…….....	_____	Carrying briefcase…….....	_____
Carrying large purse……..…...	_____	Lifting weights off floor…….....	_____	Lifting weights off table…….....	_____
Climbing stairs…….....	_____	Climbing inclines…….....	_____	Pushing things while seated.....	_____
Pushing things while standing….....	_____	Pulling things while seated….....	_____	Pulling things while seated….....	_____
Exercising upper body…….....	_____	Exercising lower body……....	_____	Exercising arms…….....	_____

Difficulties with Social and Recreational Activities

Bowling….....	_____	Fishing.....	_____	Jogging…….	_____	Biking.....	_____	Competitive sports….	_____
Dating…….	_____	Golfing…….	_____	Swimming…	_____	Skiing……..…	_____	Roller skating…….	_____
Hobbies……..	_____	Dining out…..	_____	Dancing……	_____	Boating.....	_____	Other (describe below)	_____

Difficulties with Traveling

Driving in a motor vehicle……..……..……..	_____	Driving for long periods of time……..……..	_____
Riding as a passenger……..…….	_____	Riding as a passenger on an airplane……..…….....	_____
Riding as a passenger on a train……..…….	_____	Riding as a passenger for long periods……..…….	_____

Use the following 1 to 5 scale to describe the difficulties below:
1 ="This area is not affected by my condition" 2 ="This area is slightly affected by my condition" 3 ="My condition moderately restricts my ability in the area"
4= "My condition seriously limits my ability in this area" 5="My condition prevents me from using the ability"

Difficulties with Different Forms of Communication

Concentrating…	_____	Hearing…….	_____	Reading…	_____	Using a keyboard……..…..…….	_____
Writing……...	_____	Listening……	_____	Speaking……..	_____		

Difficulties with Senses

Seeing……..	_____	Hearing…….	_____	Sense of touch…..	_____	Tasting…..	_____	Smelling……..…...	_____

Difficulties with Hand Functions

Grasping..	_____	Holding..	_____	Pinching...	_____	Percussive movements...	_____	Sensory discrimination....	_____

Difficulties with Sleep and Sexual Function

Able to have normal, restful night's sleep…….....	_____	Able to participate in desired sexual activity…..……..	_____

Please write in below any additional information regarding your Activities of Daily Living (that was not covered above)_____

_____

_____

P.I. Practice Member Provider Contract and Promissory Note

Enter This Day between Dr. John Dold (hereafter 'Provider') and _____ (hereafter 'Practice Member'). Provider hereby agrees to establish an active account for the Practice Member and to provide essential services for the purposes of benefiting and improving Practice Member's current health condition. Practice Member hereby agrees to pay Provider in full for services performed by Provider. Practice Member and Provider acknowledge that Practice Member retains any and all rights to suit to procure payment for and benefit Practice Member may be entitled.

In Consideration of and for Provider rendering essential chiropractic and/or medical services to Practice Member, and for the temporary suspension of any collection activity by Provider by the maintenance of an active account while not receiving payment at the point of service. Practice Member hereby authorizes and directs the following actions be taken on Practice Member's behalf.

I. PRACTICE MEMBER AUTHORIZATION TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Practice Member by Provider are privy of contact, and in lien of Provider sending direct billing to liability insurance carrier Practice Member authorizes and directs liability insurance company to disclose the settlement status of Practice Member's claim to Provider upon request, including settlement amounts thereof. After such time that the Practice Member has settled the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Practice Member directs the liability carrier to include the name of Provider on any check to Practice Member upon such settlement. In the event payment is made to the Practice Member attorney after settlements of the claim. Practice Member further authorizes and directs the liability company to issue a check to provider for the full amount owed for chiropractic and/or medical services rendered to fully satisfy Practice Member's obligation to Provider.

II. PRACTICE MEMBER AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If Practice Member hires an attorney; Practice Member acknowledges that Practice Member is represented by _____ Attorney at Law. Practice Member and Provider stipulate that representation by the above-named attorney prior to settlement, judgment or verdict in the Practice Member's claim. Provider shall have the option to terminate this agreement and immediately collect from the Practice Member the full amount then owed to Provider. Practice Member directs attorney to disclose to Provider upon request the settlement status and amount of Practice Member claim to include amount of all outstanding medical bill, dollar amount of any offers and counter offers a swell as date and reason of termination or dismissal, Practice Member's last address, telephone number and place of employment known to attorney. Practice Member further directs their attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement after any settlement, judgment or verdict rendered in patent claim. Practice Member acknowledges and agreements to remain personally liable to Provider for any unpaid account balance to Provider for any unpaid account balance to Provider. This agreement survives this attorney client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: In the event liability, insurance carrier or Practice Member's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Practice Member's attorney the likely representative for Practice Member.

IV. PROMISSORY NOTE: For the consideration state above; Practice Member promises to pay Provider the full balance in Practice Member's account for services rendered to Practice Member payment shall be due and payable within 30 days of the last date of services or within 3 (three) days of settlement with liability carrier for injuries sustained by Practice Member and treated by Provider, whichever event occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further, Practice Member agrees to the following:

IN THE EVENT PRACTICE MEMBER'S ACCOUNT IS NOT PAID IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PRACTICE MEMBER AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PRACTICE MEMBER ACCOUNTS SHALL BECOME DELINQUENT. IF PRACTICE MEMBER'S ACCOUNT BECOMES DELINQUENT, PRACTICE MEMBER AGREES TO PAY COLLECTION AGENCY FEES AT 16% OF THE PRACTICE MEMBER ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICES. PRACTICE MEMBER FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFORTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided the Practice Member's account remains in active status. It is agreed that, in the event, the Practice Member terminates this agreement. Practice Member shall pay full balance of Practice Member's account with 3 (three) days of termination, or the account shall be in default. Practice Member and Provider acknowledge that this document contains full, final and entire agreement between the parties. There are no other terms to this agreement. The Practice Member has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void it is expressly agreed by the parties that all remaining provisions shall remain in full force.

_____	_____	_____/_____/_____
Print Name	Signature	Date Of Agreement
_____	_____	
Witness Signature	Provider	