

# ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) \_\_\_\_\_

Today's Date: \_\_\_\_\_

## AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- Was anyone else in the vehicle with you?  No  Yes - (Number of people) \_\_\_\_\_
- You were?  Front seat – Driver / Passenger  Rear Seat – Behind Driver / Middle / Behind Passenger / 2<sup>nd</sup> Row / 3<sup>rd</sup> Row
- Name of Driver, if not self: \_\_\_\_\_ Name of Driver of other vehicle: \_\_\_\_\_
- Did airbags deploy?  No  Yes Did Police arrive?  No  Yes Using Seatbelt?  No  Yes
- Did you strike the windshield or object in car?  No  Yes - (Describe) \_\_\_\_\_
- Were you knocked unconscious?  No  Yes (How long?) \_\_\_\_\_
- Where was your vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: \_\_\_\_\_
- Where was the other vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: \_\_\_\_\_
- Your Auto Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_
  - Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- Other's Auto Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_
  - Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## GENERAL ACCIDENT/INJURY INFORMATION – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ AM / PM

Please describe the accident in as much detail as possible? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Before the accident/injury:

- Have you ever had any complaints in the involved area before?  No  Yes
  - If yes - Were they present at the time of the accident/injury?  No  Yes
    - If yes - Summarize these complaints prior to the accident: \_\_\_\_\_
- Were you capable of performing all of your work activities without restriction?  No  Yes

### At the time of the accident/injury:

- Did you feel pain immediately after the accident?  No  Yes  Later that day  Next day  When? \_\_\_\_\_
- Were you taken anywhere after the accident?  No  Yes  Later that day  Next day  When? \_\_\_\_\_
  - If yes, How? \_\_\_\_\_ Where? \_\_\_\_\_
  - If yes, Did you receive treatment?  No  Yes - (Describe) \_\_\_\_\_

### Since the accident/injury:

- Are your symptoms:  Improving?  Getting Worse?  The Same?
- Are your work activities restricted as a result of this accident/injury?  No  Yes - (How?) \_\_\_\_\_
- Have you missed any work since this accident?  No  Yes - (Dates?) \_\_\_\_\_
- Have you retained an Attorney?  No  Yes - Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  - Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient No: \_\_\_\_\_

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Phone - Home, Mobile, or Work  Other: \_\_\_\_\_

\*Referred By: (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

## Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Decline

## Preferred Language:

- English
- Spanish
- Other: \_\_\_\_\_
- Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

## Relationship:

Child  Parent  Spouse  Other: \_\_\_\_\_

## FINANCIAL INFORMATION

### Is today's visit the result of an accident?

No  Auto  Work  Other: \_\_\_\_\_

Will we be working with insurance?  No  Yes (Details)

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

### Where would you like statements sent?

Self  Other (Details below)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Account No: \_\_\_\_\_



# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: \_\_\_\_\_

Secondary Complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did it start? \_\_\_/\_\_\_/\_\_\_ What happened? \_\_\_\_\_

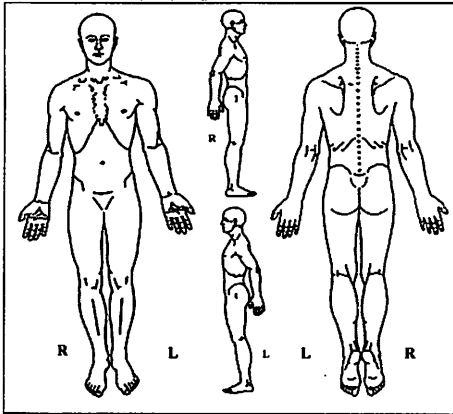
\_\_\_\_\_

Which daily activities are being affected by this condition? \_\_\_\_\_

\_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



P \_ Pain                      T \_ Tender  
 N \_ Numb                    H \_ Hypoesthesia  
 S \_ Spasm

**Quality:**

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: \_\_\_\_\_

**Does it radiate?**

- No     Yes *(Please indicate on drawing)*

**Improves with:**

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: \_\_\_\_\_
- Other: \_\_\_\_\_

**Worsens with:**

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: \_\_\_\_\_

**Previous Treatment:**

- None
- Chiropractor \_\_\_\_\_
- Medical Doctor \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ER/Urgent Care \_\_\_\_\_
- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

**Previous Diagnostic Testing:**

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

**\*Women: Are you pregnant?**

- No    Last Menstrual Period: \_\_\_/\_\_\_/\_\_\_
- Yes                      Due date: \_\_\_/\_\_\_/\_\_\_

*Present Illness Comments:*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prescription Medications & Supplements:**     None

Yes *(List - Name, dosage, frequency)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies to Medications:**     No known drug allergies

Yes *(List - Name and reaction)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# PAST, FAMILY, AND SOCIAL HISTORY

## PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

### Illnesses:

- Asthma
- Autoimmune Disorder (Type) \_\_\_\_\_
- Blood Clots
- Cancer (Type) \_\_\_\_\_
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: \_\_\_\_\_

### Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: \_\_\_\_\_

### Hospitalizations: (Non-surgical with Date)

\_\_\_\_\_

### Surgeries: (If yes, provide type & surgery date)

- Cancer \_\_\_\_\_
- Orthopedic
  - Shoulder – R / L \_\_\_\_\_
  - Elbow/Forearm – R / L \_\_\_\_\_
  - Wrist/Hand – R / L \_\_\_\_\_
  - Hip – R / L \_\_\_\_\_
  - Knee – R / L \_\_\_\_\_
  - Ankle/Foot – R / L \_\_\_\_\_

- Spinal Surgery
  - Neck: \_\_\_\_\_
  - Back: \_\_\_\_\_

- Other: \_\_\_\_\_

### Medical History Comments:

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

## FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown     Unremarkable

### Family History Comments:

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

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## SOCIAL AND OCCUPATIONAL HISTORY

**Marital Status:**  Single  Married  Divorced  Other

**Children:**  None  1  2  3  4  Other: \_\_\_\_\_

**Student Status:**  Full Student  Part Student  Non-Student

**Highest level of Education:**  High School  College Grad.

Post Grad.  Other: \_\_\_\_\_

**Employed:**  No  Yes (Occupation) \_\_\_\_\_

**Dominant Hand:**  Right  Left  Ambidextrous

**Smoking/Tobacco Use:** If current smoker, amount = \_\_\_\_\_

- Every Day  Some Days  Former  Never

### Alcohol Use:

- Every Day  Weekly  Occasionally  Never

### Caffeine Use:

- Coffee  Tea  Energy Drinks  Soda  Never

### Exercise frequency:

- Daily  3-4xs/week  2-3xs/week  Rarely  Never

**Social History Comments:** \_\_\_\_\_

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# REVIEW OF SYSTEMS

REVIEW OF SYSTEMS

***Many of the following conditions respond to chiropractic treatment.***

Are you **currently** experiencing any of these symptoms? (Please select all that apply and use comments to elaborate.)

**Constitutional:** (General)

- Fever
- Fatigue
- Other: \_\_\_\_\_
- None in this Category

**Musculoskeletal:**

- Joint Pain/Stiffness/Swelling
- Muscle Pain/Stiffness/Spasms
- Broken Bones \_\_\_\_\_
- Other: \_\_\_\_\_
- None in this Category

**Neurological:**

- Dizziness or Lightheaded
- Convulsions or Seizures
- Tremors
- Other: \_\_\_\_\_
- None in this Category

**Psychiatric:** (Mind/Stress)

- Nervousness/Anxiety
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: \_\_\_\_\_
- None in this Category

**Genitourinary:**

- Frequent or Painful Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Painful or Irregular Periods
- Other: \_\_\_\_\_
- None in this Category

**Gastrointestinal:**

- Loss of Appetite
- Blood in Stool or Black Stool
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: \_\_\_\_\_
- None in this Category

**Cardiovascular & Heart:**

- Chest Pains/Tightness
- Rapid or Heartbeat Changes
- Swelling of Hands, Ankles, or Feet
- Other: \_\_\_\_\_
- None in this Category

**Respiratory:**

- Difficulty Breathing
- Cough
- Other: \_\_\_\_\_
- None in this Category

**Eyes & Vision:**

- Eye Pain
- Blurred or Double Vision
- Sensitivity to Light
- Other: \_\_\_\_\_
- None in this Category

**Head, Ears, Nose, & Mouth/Throat:**

- Frequent or Recurrent Headaches
- Ear - Ache/Ringing/Drainage
- Hearing Loss
- Sensitivity to Loud Noises
- Sinus Problems
- Sore Throat
- Other: \_\_\_\_\_
- None in this Category

**Endocrine:**

- Infertility
- Recent Weight Change
- Eating Disorder
- Other: \_\_\_\_\_
- None in this Category

**Hematologic & Lymphatic:**

- Excessive Thirst or Urination
- Cold Extremities
- Swollen Glands
- Other: \_\_\_\_\_
- None in this Category

**Integumentary:** (Skin, Nails, & Breasts)

- Rash or Itching
- Change in Skin, Hair, or Nails
- Non-healing Sores or Lesions
- Change of Appearance of a Mole
- Breast Pain, Lump, or Discharge
- Other: \_\_\_\_\_
- None in this Category

**Allergic/Immunologic:**

- Food Allergies
- Environmental Allergies
- Other: \_\_\_\_\_
- None in this Category

Review of Systems Comments:

\_\_\_\_\_

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I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Chiropractic and Acupuncture Inc**  
**Dr. Garrett Bary, D.C., F.A.A.C.A., C.C.C.N.**  
**13740 North Highway 183, Suite K4, Austin, Texas 78750**  
**P 512.343.2279 F 512.590.8712**

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**CHIROPRACTIC INFORMED CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Name Printed of Guardian/Parental and Relationship to Patient: \_\_\_\_\_

Guardian/Parental Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor of Chiropractic Name: Garrett Bary DC \_\_\_\_\_

Signature of Doctor of Chiropractic: \_\_\_\_\_

Date: \_\_\_\_\_

**Chiropractic and Acupuncture Inc.  
13740 North Highway 183, Suite, K4, Austin, TX 78750**

**Assignment of Benefits: Assignment of Cause of Action: Contractual Lien**

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Garrett Bary, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

**RELEASE OF INFORMATION:** You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

**IRREVOCABLE ASSIGNMENT OF RIGHTS:** You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

**DEMAND FOR PAYMENT:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Chiropractic and Acupuncture Inc, and send to 13740 North Highway 183, Suite K4, Austin, TX, 78750.

**THIRD PARTY LIABILITY:** If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Chiropractic and Acupuncture Inc, and to send any and all checks to 13740 North Highway 183, Suite K4, Austin, TX, 78750.

**STATUTE OF LIMITATIONS:** I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

**LIMITED POWER OF ATTORNEY:** I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

**REJECTION IN WRITING:** I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

**TERMINATION OF CARE:** I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

\_\_\_\_\_  
Date:\_\_\_\_\_