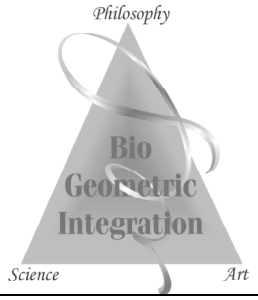
Hardwick Chiropractic

54 School Circle
East Hardwick, VT 05836
802.472.3033 802.472.3022 fax



Dr. Grace Johnstone
Dr. Rick Eschholz
Dr. Teri Dodge

PERSONAL INJURY QUESTIONNAIRE

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please answer the questions below as completely as possible. Thank you.

Name: _____ Home Phone:

_____

Address: _____ Business Phone:

_____

_____ Email:

_____

City: _____State: _____Zip: _____Occupation: _____

Date of Birth: _____ Age: _____ M____F____ Married_____ Partnership_____ No. Of Children_____

Social Security Number: _____Insurance: _____Claim #_____

How did you hear about our office?

_____

Give time and date present injury occurred_____ AM PM _____, 20_____

Please explain in detail how your accident happened_____

_____

_____

_____

Where did you feel pain immediately after the accident?_____

Description of pain: _____ Frequency of

pain:_____

_____

Level of pain initially:
1 2 3 4 5 6 7 8 9 1 0
<least more>
Level of pain presently:
1 2 3 4 5 6 7 8 9 1 0

☐ Constant ☐ Daily ☐ Intermittent ☐ With Activity ☐ Occasional

☐ Other:_____

Did you require post accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

☐Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach Upset	☐ Light Bothers Eyes	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Seems to be Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Fainting	☐ Sleeping Problems	☐ Loss of Balance	☐ Back Pain
☐ Face Flushed	☐ 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	☐ _____	☐ _____

Symptoms other than above:_____
_____

Where were you taken after the injury? _____
Name of hospital_____
Name of doctors_____
What treatment was given?_____
Did you consult any other doctor? ☐ Yes ☐ No
If so, give doctor's name_____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.
Doctor's diagnois_____
What treatment was given?_____
How often did you see the doctor?_____
Have you ever had any complaints in the involved area before? ☐ Yes ☐ No If so, what were the complaints?_____
Have you ever had a workers compensation claim before? ☐ Yes ☐ No
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 injury? ☐ Yes ☐ No
Since this injury are your symptoms? ☐ Improving? ☐ Getting worse? ☐ The same?
Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe
If so, name and address_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature:_____Date:_____

Guardian's signature:_____Date:_____