PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

Patients Name: ____

Address: ____

City, State Zip: ____

SSN: __________________________ Date of Birth: __________________

Gender: Male Female

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Home Number: __________________________

Work Number: __________________________

Cell Phone: __________________________

Email Address: __________________________

Occupation _______________________ Employer ______________________

What are your job requirements? ____

Who were you referred by? ____

What is your major complaint? ____

Injury History

1. Date of Injury: _______________________ Time: ____________AM PM
2. Please describe IN DETAIL how the injury occurred in your own words:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Symptoms

3. Are you right or left handed? ☐ Right ☐ Left
4. Immediately after the injury occurred were you:
   ☐ conscious ☐ dazed ☐ unconscious
5. At the time of the incident, where did you experience pain? Be specific:
   ____
   ____

Please list ONE BODY PART per complaint.

6. **Complaint #1**:
   What is your major complaint? ____
   When did your symptoms begin: ☐ immediately ☐ hrs/days/weeks after
   What percentage of the time do you experience/feel this symptom? ______%
   What activities make this symptom worse? ____________________________
   What makes this symptom better? ____________________________________
   Can/Do you have this symptom without activity? ________________________
   Pain Scale (circle): Mild Moderate Severe
   Has this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse
   Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Excercise

7. **Complaint #2:**
   What is your major complaint? ____
   When did your symptoms begin: ☐ immediately ☐ hrs/days/weeks after
   What percentage of the time do you experience/feel this symptom? ______%
   What activities make this symptom worse? ____________________________
   What makes this symptom better? ____________________________________
   Can/Do you have this symptom without activity? ________________________
   Pain Scale (circle): Mild Moderate Severe

Has this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Excercise

8. **Complaint #3:**

What is your major complaint? ______________________________________

When did your symptoms begin: ☐ immediately ☐ hrs/days/weeks after

What percentage of the time do you experience/feel this symptom? ______%

What activities make this symptom worse? ___________________________

What makes this symptom better? __________________________________

Can/Do you have this symptom without activity? _______________________

Pain Scale (circle): Mild Moderate Severe

Has this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Excercise

If you are experiencing additional complaints please list on the back.

9. Have you lost any days of work from this injury? ☐ yes ☐ no Dates:_______

If yes, explain: ____

____ ______

Treatment Received

10. Please list ALL doctors you have seen regarding this accident. Please List them in chronological order/the order you saw them in:

Did you go to the **Hospital**? ☐ yes ☐ no

If yes, when? ☐ right after the injury occurred ☐ next day ☐ other: ____________

If yes, how did you get there? (i.e., ambulance, drove) other: __________________

If by ambulance, did the ambulance attendants place you in a: ☐ neck brace

☐ back brace ☐ other ____

Did the ambulance administer any medication or medical supplies?

____

Name of hospital: ____

Name of doctor: ____

Diagnosis: ____

Treatment Received: ____

Were any medications prescribed? ____

Did you have x-rays taken at the hospital? ☐ yes ☐ no

Did you have an MRI at the hospital? ☐ yes ☐ no

Name of Doctor/Facility #1: _______________________ City/Location: ___________

Type of Doctor (degree or specialty): _____________________________________

Describe the treatment and/or tests received: _______________________________

____

What did this doctor say was wrong with you? ______________________________

____

Date when treatment started: _________ Date when treatment stopped: _________

How many treatments/visits were there? ____ How long were the treatments? _____

What was the result/outcome of the treatment? _____________________________

____

Still Treating with this doctor? ___ Yes ___ No If “Yes”, how often? __________

Name of Doctor/Facility #2: _______________________ City/Location: ___________

Type of Doctor (degree or specialty): _____________________________________

Describe the treatment and/or tests received: _______________________________

____

What did this doctor say was wrong with you? ______________________________

____

Date when treatment started: _________ Date when treatment stopped: _________

How many treatments/visits were there? ____ How long were the treatments? _____

What was the result/outcome of the treatment? _____________________________

____

Still Treating with this doctor? ___ Yes ___ No If “Yes”, how often? __________

If you sought any additional treatment please list the physician(s)’s information on the back.

Patient History

11. Have you had any similar problems before? ☐ yes ☐ no
12. Medications, dosage, frequency and reason: _______________________________

    ____
13. List surgical operations and years: ______________________________________

    ____
14. Are you diabetic? ☐ yes ☐ no
15. Do you have high blood pressure? ☐ yes ☐ no

16. Do you have low blood pressure? ☐ yes ☐ no
17. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no
18. Prior sports related injuries: ____
    ____
19. Prior motor vehicle crashes: ____
    ____
20. Prior work related injuries: ____
    ____

Our office offers appointment reminders via text messages OR E-Mail, which would you prefer?

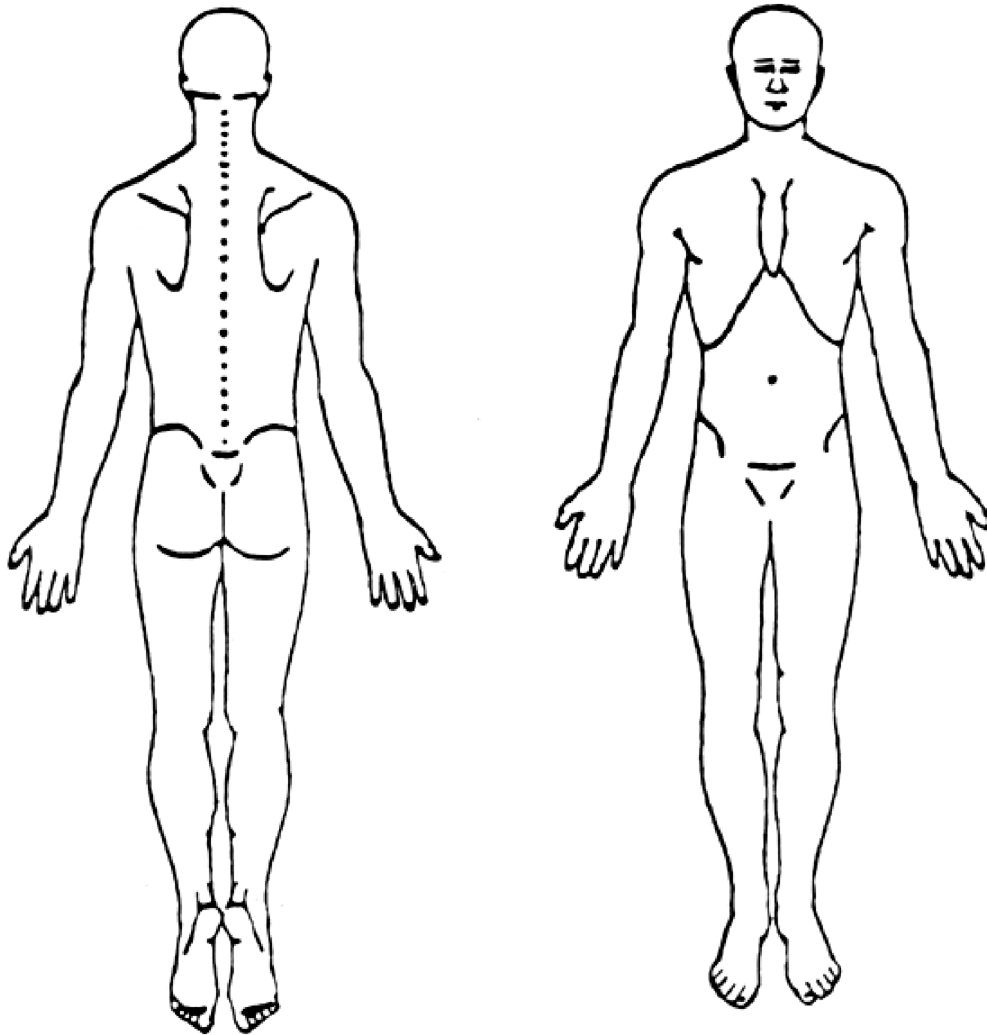
If you prefer text message, what is your cell provider (i.e. Verizon, Sprint)?

When would you prefer to receive your reminder? 1 hour 2 hours 4 hours 1 day 2 days

CURRENT SYMPTOMS:

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies). Also, Review The Pain Scale On The Bottom Of This Page. The Doctor Will Be Asking You Questions.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE

0-1	=	**Minimal**	=	The pain is an annoyance but does not stop me from working.
2-3	=	**Slight**	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	**Moderate**	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	**Moderate To Severe**	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	**Severe**	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on ______________________________________, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____________.

______________________________ Patient's Name (Print)

______________________________ Patient's Signature

_____________ Date

______________________________ Relationship or authority if not signed By patient

______________________________ Witness

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PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER
____
____
____
____

Provider:
Unruh Chiropractic, Inc.
23043 Lyons Avenue
Santa Clarita, CA 91321
(661) 288-0022

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: __________________________

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. ______

I agree that if my injuries are the result of a third party liability the third party is responsible for my bills and my personal health insurance cannot be billed. I agree and understand that if my case is not paid by the resolution of my injury/illness case then my personal health insurance may be billed. I understand that I am responsible for any balance in full not allowed/covered by my personal health insurance. ______

I fully understand that payment to provider is due three years from the date of injury/illness regardless of the resolution/status of my case. ______

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

I further agree to inform said provider of any change in my attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that I am handling the case on my own. I also agree that I am responsible for having my attorney sign this lien within 30 days of acquiring new representation. ______

I also agree to inform said provider within 15 days of any resolution of the case by settlement, verdict, or arbitration. ______

Patient's Signature: ______________________________ Dated: ____________

Patient’s Name (print): ____________________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney further agrees to inform said provider of any change in patient’s attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that the patient is handling the case in prop per. Attorney also agrees to inform said provider within 15 days of any resolution of the case by settlement, verdict, arbitration or award or that the case is no longer being pursued by the patient.

Attorney's Signature: ____________________________ Dated: ____________

Please sign, retain a copy for your records, and return this copy to us promptly.

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER
____
____
____
____

Provider:
Thrive Medical, Ins.
23043 Lyons Avenue
Santa Clarita, CA 91321
(661) 288-0022

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: ___________________________

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. ______

I agree that if my injuries are the result of a third party liability the third party is responsible for my bills and my personal health insurance cannot be billed. I agree and understand that if my case is not paid by the resolution of my injury/illness case then my personal health insurance may be billed. I understand that I am responsible for any balance in full not allowed/covered by my personal health insurance. ______

I fully understand that payment to provider is due three years from the date of injury/illness regardless of the resolution/status of my case. ______

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

I further agree to inform said provider of any change in my attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that I am handling the case on my own. I also agree that I am responsible for having my attorney sign this lien within 30 days of acquiring new representation. ______

I also agree to inform said provider within 15 days of any resolution of the case by settlement, verdict, or arbitration. ______

Patient's Signature: _______________________________ Dated: ____________

Patient’s Name (print): _____________________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney further agrees to inform said provider of any change in patient’s attorney representation by sending written notice to said provider of the name, address and telephone of the new attorney representation or that the patient is handling the case in prop per. Attorney also agrees to inform said provider within 15 days of any resolution of the case by settlement, verdict, arbitration or award or that the case is no longer being pursued by the patient.

Attorney's Signature: _____________________________ Dated: ____________

Please sign, retain a copy for your records, and return this copy to us promptly.

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OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. The policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Unruh Chiropractic, Inc. or Thrive Medical, Inc. I assign and authorize payments to Unruh Chiropractic, Inc. or Thrive Medical, Inc. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

Insurance figures are **ESTIMATES ONLY!** It is not easy for an office to become familiar with the exact details of every Insurance Plan it encounters. **It is the responsibility of the patient, NOT the doctors' office to know what is covered and what is excluded from their particular Insurance Plan.**

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. **We DO NOT accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.**

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard of care in this area. **If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim.**

If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

As the patient you agree that you are seeking care under your accord if your insurance denies your care for any reason, including but not limited to medical necessity, timely filing, etc.

Cancellation Fee: We do not over-book our physician's schedules. We want every patient to be able to receive the care that they need. Therefore, when you cancel or do not show up to your appointment you are preventing someone else from getting the care they need.

If you do not cancel your appointment within 4 hours of your scheduled time or if you do not show up to your appointment you will be charge a **$25 cancellation fee** due on your next date of service.

____ _______________
Signature of Patient or Guardian Date

____ _______________
Printed Name of Patient or Guardian Relationship to Patient

Patient Name: ______________________________________

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be authority for any dispute to be decided on a class action basis. Anrbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider. Including those working at the health care provider's clinic or office or any other clinic or office whether signatores to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation. partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) **shall be** selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay **such** party's pro rata share of **the** expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to **bifurite** the issues of liability and damage upon written request to the neutral arbitrator.

The parties cosent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall he arbitrated in one proceeding. A claim shall be waived end forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here.______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

______________________________	____________	______________________________
Patient Signature (Or patient representative)	Date	(Indicate relationship if signing for patient)
______________________________	____________	
Office Signature	Date	

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Insurance Information

Date of Injury: _____________

Patient: _____________

Patient's Health Insurance

Insurance Company: ____

Policy Number: ____

Claim Number: ____

Adjuster Name: ______________________ Phone:_______________________

Address: ____

Responsible Parties Insurance

Insurance Company: ____

Policy Number: ____

Claim Number: ____

Adjuster Name: ______________________ Phone:_______________________

Address: ____

Patient's Attorney

Name: _________________________ Phone: ____________________

Address: ____

Patient Signature _______________________________ Date ____________

Parent/Guardian _______________________________ Date ____________

Print Name ____________________________________