# ***Personal Injury Questionnaire***

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Age ____ Birth Date _____ E-mail _____ Sex ____ S/S No. _____

Employer's Name _____ Employer's Address _____

Your Auto Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If Other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holders' Name _____ Policy# _____

**ATTORNEY INFO**

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( )Yes ( )No Name(s) _____

**NATURE OF ACCIDENT:**

1. Date of Accident: _____ Time of Day: _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
5. What direction was other vehicle headed: ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right Side
7. Approximate speed of your car _____mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were the police notified? ( ) Yes ( ) No If yes, please let us copy the Police Report.
10. In your own words, please describe accident: _____

_____

_____

_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: _____

_____

_____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    D. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe: _____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

16. Have you ever been involved in an accident before: ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received._____

_____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

_____

19. Since the injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

| | | | | |
|---|---|---|---|---|
| ☐ Headache | ☐ Irritability | ☐ Numbness in Toes | ☐ Face Flushed | ☐ Feet Cold |
| ☐ Neck Pain | ☐ Chest Pain | ☐ Shortness of Breath | ☐ Buzzing in Ears | ☐ Hands Cold |
| ☐ Neck Stiff | ☐ Dizziness | ☐ Fatigue | ☐ Loss of Balance | ☐ Stomach Upset |
| ☐ Sleeping Problems | ☐ Head Seems Heavy | ☐ Depression | ☐ Fainting | ☐ Constipation |
| ☐ Back Pain | ☐ Pins & Needles in Arms | ☐ Lights Bother Eyes | ☐ Loss of Smell | ☐ Cold Sweats |
| ☐ Nervousness | ☐ Pins & Needles in Legs | ☐ Loss of Memory | ☐ Loss of Taste | ☐ Fever |
| ☐ Tension | ☐ Numbness in Fingers | ☐ Ears Ring | ☐ Diarrhea | ☐ _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

_____

23. Other pertinent information: _____

_____

_____ _____

Date Patient's Signature

# Chait Chiropractic Center  Patient Health History

**How did you hear about our office?** _____ **Referred By:** _____

**Today's Date** [ / / ] **Signature of Patient** _____

**Patient Title:** *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

**First Name** _____ **Nick Name** _____

**Last Name** _____ **Middle Name** _____ **Suffix** _____

**Address 1** _____

**Address 2** _____

**City** _____ **State** _____ **Zip Code** _____

**Home Phone** _____ **Mobile Phone** _____

**Home email** _____

**Contact Method** *(check one)*

❑ Home Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

**Date of Birth** [ / / ] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

**Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

**Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**Payment Method: Cash ❑ Credit Card ❑ Private Insurance ❑ Medicare ❑ Medicaid ❑**

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

***If yes, how often do you smoke:*** ❑ Current every day smoker ❑ Current sometimes smoker

***If yes, what is your level of interest in quitting smoking?***

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

*No interest* *Very Interested*

**Do you currently drink alcoholic beverage of any kind?** ❑ Yes ❑ Former drinker ❑ Never been a drinker

***If yes, how often do you drink:*** ❑ Current every day drinker ❑ Current sometimes drinker

***If yes, what is your level of interest in quitting drinking?***

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

*No interest* *Very Interested*

**Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑**

| | Start Date | | Start Date |
|---|---|---|---|
| 1) | | 5) | |
| 2) | | 6) | |
| 3) | | 7) | |
| 4) | | 8) | |

**List any known allergies you have had to any medications. If no allergies are known, check here: ❑**

1) _____ 3) _____

2) _____ 4) _____

**Current vitamins, including frequency and dosage if known.** _____

_____

**Briefly list your main health problems:** _____

_____

**Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No

If yes, describe: _____

**Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure

***If yes, other comments regarding Diabetes:*** _____

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ❑ Yes ❑ No

*For office use only*

## History of Complaint

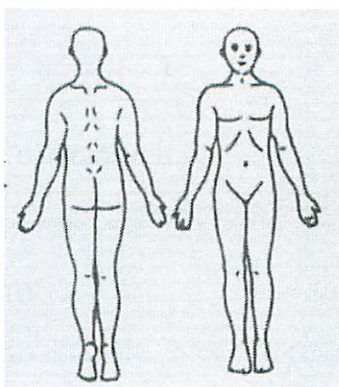
Please identify the condition(s) that brought you to this office:

Primarily: _____ Secondarily: _____
Third: _____ Fourth: _____

Instructions: Please circle the number that best describes the questions being asked.
**What is your pain right now?** : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**What is your typical pain?** : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**What is your pain at its best?** : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**What is your pain at its worst?** : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When and how did the problem(s) begin? _____
When is the problem at its worst? AM PM mid-day late PM
What is the frequency of discomfort? Continuous Intermittent Occasional Frequent
Was the condition treated by anyone in the past? Yes ❑ No ❑
If yes by whom?_____ What were the results?_____
Have you ever seen a chiropractor? Yes ❑ No ❑

***PLEASE MARK** the areas on the
diagram with the following **letters** to describe your symptoms:
**R = Radiating B = Burning D = Dull A = Aching, DP = Deep, C = Cramping, SF = Stiffness**
**N = Numbness S = Sharp, ST = Stabbing, T= Tingling, TH = Throbbing**



**My condition is a result of:**
[ ] Prolonged Position [ ] Prolonged Activity
[ ] Over exertion [ ] Awkward Motion
[ ] A worsening long-term problem
[ ] An accident or injury: [ ] Work [ ] Auto
[ ] Other:_____
What makes it feel worse? _____
What makes it feel better? _____

**Activities of Daily Life:** Please identify how your current condition is affecting your ability
to carry out activities that are routinely part of your life:

Lifting Objects □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Sit to Stand □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Climbing Stairs □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Concentration □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Household Chores □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Grooming □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Bending Over □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Sleep □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Sitting □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Standing □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform
Walking □ No Effect □ Mild Effect □ Moderate Effect □ Unable to Perform

**What are you goals for care in our office?**
[ ] I just want relief of my immediate pain
[ ] I would like to address the underlying problem.
[ ] I am interested in being the healthiest I can be and learning how to stay that way.
[ ] Other: _____

*for office use only*

## Review of Systems

Please check any of the following you may have had or have

**Musculoskeletal**
[ ] Osteoporosis [ ] Arthritis [ ] Scoliosis [ ] Neck pain [ ] Back pain
[ ] Hip disorders [ ] Knee problems [ ] Foot/ankle [ ] Shoulder issues [ ] Elbow/wrist issues
[ ] TMJ issues [ ] Poor posture

**Neurological**
[ ] Anxiety [ ] Depression [ ] Dizziness [ ] Pins & needles [ ] Numbness

**Cardiovascular**
[ ] High blood pressure [ ] Low blood pressure [ ] High cholesterol
[ ] Poor circulation [ ] Excessive bruising [ ] Angina

**Respiratory**
[ ] Asthma [ ] Sleep apnea [ ] Emphysema [ ] Hay fever
[ ] Pneumonia [ ] Shortness of breath

**Digestive**
[ ] Anorexia [ ] Bulimia [ ] Food sensitivities [ ] Heartburn
[ ] Constipation [ ] Diarrhea

**Sensory**
[ ] Blurred vision [ ] Ears ringing [ ] Hearing loss [ ] Chronic ear infection
[ ] Loss of smell [ ] Loss of taste

**Integumentary**
[ ] Skin cancer [ ] Psoriasis [ ] Eczema [ ] Acne
[ ] Rash [ ] Hair loss

**Endocrine**
[ ] Thyroid issues [ ] Immune disorders [ ] Hypoglycemia [ ] Frequent infection
[ ] Swollen glands [ ] Low energy

**Genitourinary**
[ ] Kidney stones [ ] Infertility [ ] Frequent urination [ ] Prostate issues
[ ] Erectile dysfunction [ ] PMS symptoms

**Constitutional**
[ ] Fainting [ ] Low libido [ ] Poor appetite [ ] Fatigue [ ] Weakness
[ ] Sudden weight loss or gain (circle one)

**Does anyone in your family suffer with the same condition(s)?** No Yes
**If yes whom:** grandmother grandfather mother father sisters brothers sons daughters
**What type of condition**:

_____

**Any other hereditary conditions the doctor should be aware of?** No Yes:

_____

**Have you ever seen a chiropractor before?** Yes No
**If yes, Whom?** _____
**What was your experience?** _____

**What position do you sleep in?** [ ] side [ ] back [ ] stomach [ ] sitting
**Is there anything else you'd like the doctor to be aware of?**_____

_____

Are you wearing Heel Lifts ( ) Arch Supports ( )

*For office use only*

**Please list any major injuries, illnesses, surgeries and treatments you may have had or have.**

| Illness | Operations | Treatments | Injuries |
|---|---|---|---|
| [ ] AIDS | [ ] Appendix | [ ] Acupuncture | [ ] Broken bone |
| [ ] Alcoholism | [ ] Bypass surgery | [ ] Antibiotics | [ ] Car accident |
| [ ] Allergies | [ ] Cancer | [ ] Chemotherapy | [ ] Knocked unconscious |
| [ ] Arteriosclerosis | [ ] Eye surgery | [ ] Chiropractic care | [ ] Spine disorder |
| [ ] Cancer | [ ] Hysterectomy | [ ] Dialysis | [ ] Nerve disorder |
| [ ] Chicken pox | [ ] Pacemaker | [ ] Herbs | [ ] Hernia |
| [ ] Diabetes | [ ] Spine: _____ | [ ] Hormone replacement | |
| [ ] Epilepsy | [ ] Tonsillectomy | [ ] Inhaler | |
| [ ] Glaucoma | [ ] Vasectomy | [ ] Massage | |
| [ ] Gout | [ ] Physical therapy | | |
| [ ] Heart disease | [ ] Hernia repair | | |
| [ ] Hepatitis | [ ] Other: _____ | | |
| [ ] HIV Positive | _____ | | |
| [ ] Malaria | | | |
| [ ] Measles | | | |
| [ ] Multiple Sclerosis | | | |
| [ ] Mumps | | | |
| [ ] Polio | | | |
| [ ] Rheumatic fever | | | |
| [ ] Scarlet fever | | | |
| [ ] Sexually transmitted disease | | | |
| [ ] Stroke | | | |
| [ ] Tuberculosis | | | |
| [ ] Typhoid fever | | | |
| [ ] Ulcers | | | |

**Acknowledgements**

Initials ____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing are from medicine and does not proclaim to cure any named disease or entity.

Initials ____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement for any involved third parties.

Initials ____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I'm responsible for the payment of any covered or non-covered services that I receive.

Initials ____ I hereby authorize payment to be made directly to John R. Chait, Inc. for all benefits which may be payable under a healthcare plan or from any other collateral sources.

Initials ____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

**Patient or Authorized Person's Signature** **Date Completed**

# INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Dr. John R. Chait:

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examinations, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic names above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

**SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

X _____

Printed name of Patient

X _____ _____

Signature of Patient Date

X _____ _____

Signature of Representative Date
(If patient is a minor or handicapped)

X _____ _____

Witness to Patient's Signature Date

## X-RAY INFORMATION

Patient _____ Date _____

Female Patients...
Is it possible that you are pregnant? YES NO (Circle One)

First day of last menstrual period ____/____/____

Type of birth control used _____

Signature _____

| View | KVP | MA | Dist | Cm | Time |
|---|---|---|---|---|---|
| APL | 80 | 200 | 40 | | |
| LL | 80 | 200 | 40 | | |
| APT | 80 | 200 | 40 | | |
| APTC | 80 | 200 | 40 | | |
| LT | 80 | 200 | 40 | | |
| APC | 80 | 200 | 40 | | |
| LC | 80 | 200 | 72 | | |
| APOM | 80 | 200 | 40 | | |
| RPO | 80 | 200 | 40 | | |
| LPO | 80 | 200 | 40 | | |
| FLEX | 80 | 200 | 72 | | |
| EXT | 80 | 200 | 72 | | |
| AP SHLDR | 80 | 200 | 40 | | |
| L SCAPLA | 80 | 200 | 40 | | |
| AP ELBOW | 60 | 50 | 40 | | |
| L ELBOW | 60 | 50 | 40 | | |
| AP HAND | 60 | 50 | 40 | | |
| L HAND | 60 | 50 | 40 | | |
| AP KNEE | 80 | 100 | 40 | | |
| L KNEE | 80 | 100 | 40 | | |
| AP FOOT | 60 | 50 | 40 | | |
| L FOOT | 60 | 50 | 40 | | |
| OTHER | | | | | |
| OTHER | | | | | |
| OTHER | | | | | |
| OTHER | | | | | |

# Functional Rating Index

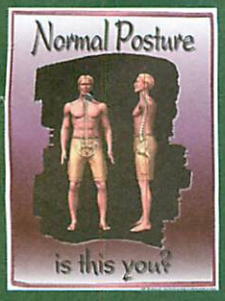
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the answer which most closely describes your condition right now.**

| | | | | | |
|---|---|---|---|---|---|
| **1. Pain Intensity** | No pain (0) | Mild pain (1) | Moderate pain (2) | Severe pain (3) | Worst possible pain (4) |
| **2. Sleeping** | Perfect sleep (0) | Mildly disturbed sleep (1) | Moderately disturbed sleep (2) | Greatly disturbed sleep (3) | Totally disturbed sleep (4) |
| **3. Personal Care (washing, dressing etc.)** | No pain no restrictions (0) | Mild pain no restrictions (1) | Moderate pain need to go slowly (2) | Moderate pain need some assistance (3) | Severe pain need 100% assistance (4) |
| **4. Travel (driving, etc.)** | No pain on long trips (0) | Mild pain on long trips (1) | Moderate pain on long trips (2) | Moderate pain on short trips (3) | Severe pain on short trips (4) |
| **5. Work** | Can do usual work plus unlimited extra work (0) | Can do usual work no extra work (1) | Can do 50% of usual work (2) | Can do 25% of usual work (3) | Cannot work (4) |
| **6. Recreation** | Can do all activities (0) | Can do most activities (1) | Can do some activities (2) | Can do few activities (3) | Cannot do any activities (4) |
| **7. Frequency of pain** | No pain (0) | Occasional pain 25% of day (1) | Intermittent pain 50% of the day (2) | Frequent pain 75% of the day (3) | Constant pain 100% of the day (4) |
| **8. Lifting** | No pain with heavy weight (0) | Increased pain with heavy weight (1) | Increased pain with moderate weight (2) | Increased pain with light weight (3) | Increased pain with any weight (4) |
| **9. Walking** | No pain any distance (0) | Increased pain after 1 mile (1) | Increased pain after ½ mile (2) | Increased pain after ¼ mile (3) | Increased pain any distance (4) |
| **10. Standing** | No pain after several hours (0) | Increased pain after several hours (1) | Increased pain after 1 hour (2) | Increased pain after ½ hour (3) | Increased pain with any standing (4) |

**Name:** _____ _____ Total Score _____

**PRINTED** **Date**




**Chait Chiropractic Center**

4221 Bee Ridge Road
Sarasota, FL 34233

941-371-1070 (office)
941-379-2500 (fax)
Website: Chaitchiropractic.com

# Disclosure, Acknowledgment & Notice of Initiation of Treatment Pursuant to Section 627.736 Florida Statutes

On this date of initial treatment or service provided, the undersigned physician hereby gives notice of providing medical services upon which a claim for personal injury protection benefits is based; and likewise, follows the requirements of law by signing below and requiring the patient's signature below for executing this acknowledgement and disclosure form, to agree and reflect the following:

a. The insured, or his or her guardian, signs below attesting to the fact that the services identified as: Comprehensive History/ Exam, (4) Full Spine X-rays, (4) Cervical X-rays were actually rendered;

b. The insured, or his or her guardian, has both the right and the affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician rendering services for which payment is being claim explained the services to the insured or his or her guardian;

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer;

f. This Acknowledgment, Disclosure and Notice shall also serve as notice of initiation of treatment.

_____

Provider's Handwritten Signature  Patient's Handwritten Signature

_____

Date  Patient Printed Name

# *Assignment of Insurance Benefits*

I, _____ Hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by ***John R. Chait, Inc.*** but not to exceed the charges of those services, payable to and mailed directly to:

**JOHN R. CHAIT, INC.**
**CHAIT CHIROPRACTIC CLINIC**
**4221 BEE RIDGE ROAD**
**SARASOTA, FL 34233**

Furthermore, I hereby IRREVOCABLY ASSIGN to ***John R. Chait, Inc.*** the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by ***John R. Chait, Inc.***

Phone confirmation is not a guarantee of benefits. Patient acknowledges that in the event that the insurance company fails to pay any portion of the doctors bills, that patient is liable and responsible for said payments and shall promptly make said payments upon request from doctor's office.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this ____ day of _____, 20__.

_____
(Patient's Signature)