PERSONAL INJURY QUESTIONNAIRE

Name ____ Phone____________________________

Address ____ City __________________________________

State _________ Zip ____________ Age ________ Birthday _______ / ______ /_________ Gender _______________

Responsible Party's Name ____

Address ____ City ________________ State ________ Zip ___________

Claim Reprehensive ____Phone_______________________________

Fax #___________________________________ Claim # ____

Ins. Co. ____ Phone_____________________________

ATTORNEY

Name ____ Phone ________________________

Address ____ City ________________ State_______ Zip _______

Were there any witnesses? ( ) Yes ( ) No Names(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 police notified? ( ) Yes ( ) No
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 & symptoms: ____
____
____.

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

15. Do you have any previous illnesses that 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 injuries 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 this injury occurred, are you symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

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

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**

PERSONAL INJURY

FINANCIAL POLICY STATEMENT / DR.'S LIEN

I hereby acknowledge that I am receiving, or am about to receive, health care services from Craig Bowars, DC, and/or his staff. **I understand that I am financially responsible for all services, nutritional supplements, and medical supplies I receive from Dr. Bowars and/or his staff. I agree to pay for all nutritional supplements at the time I receive them** with the understanding that I will be reimbursed if insurance also pays for the supplements. I understand that Dr. Bowars is willing to wait for payment for his services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that:

1. If it is determined that an insurance company is not obligated to pay for the services rendered by Dr. Bowars and/or his staff, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor, I agree to pay the entire balance of my account within ninety (90) days after my most recent office visit with Dr. Bowars.
2. If a liability claim exists, but my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney, then payment for all services rendered by Dr. Bowars and /or his staff will be due at the time of service and my bill will be paid in full as soon as the liability claim is settled.
3. If an insurance company pays me directly for services rendered by Dr. Bowars and/or his staff, I am obligated to turn that payment over, upon receipt by me, to Dr. Bowars to cover any outstanding balance on my account. If I violate this agreement and do not send the payment to Dr. Bowars, I will be required to pay the entire balance within thirty (30) days of my last treatment.

Patient's Full Name (printed): ____

Patient/Guardian Signature: ____ Date: ______________

Authorization to Release Information: I authorize the release of any medical or other information necessary to my/other party's insurance company or attorney if deemed necessary, either by my/other party's insurance company, attorney or my/other party's physician at this clinic in order to process a claim.

Patient/Guardian Signature: ____ Date: ______________

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of disease." A vitamin is not a drug. Neither is a mineral, a trace element, an amino acid, an herb, or homeopathic remedy. Although a vitamin, a mineral, a trace element, an amino acid, an herb or a homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Patient/Guardian Signature: ____ Date: ______________

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance company or attorney, your health information on this form may be shared with them. Your health information which your insurance company or attorney sees will be kept confidential by them