



**PERSONAL INJURY QUESTIONNAIRE (MVA) / PERSONAL INFORMATION**

Today's Date: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

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

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Left-Handed  Right-Handed

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

Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer at Time of Accident: \_\_\_\_\_ Occupation: \_\_\_\_\_

Brief Job Description: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_

Have been off work because of this accident? Yes No If Yes, dates from: \_\_\_\_\_ to \_\_\_\_\_

Marital Status: (Circle One) Married Divorced Single Spouse's Name: \_\_\_\_\_

Have you had previous chiropractic care? Yes No If yes, when was your last visit? \_\_\_\_\_

If you discontinued care, why? \_\_\_\_\_

How long were you receiving adjustments? \_\_\_\_\_ How often did you go? \_\_\_\_\_

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods were used?

\_\_\_\_\_



Do you have any numbness or tingling in your  legs  feet  toes  arms  hands  fingers?

What is your most COMFORTABLE position?  sitting  lying on right side  lying on left side  stomach  back  
 standing  If other, please describe: \_\_\_\_\_

Do you have trouble changing positions in bed?  Yes  No

Does stretching and twisting worsen the pain?  Yes  No

Do any of the following relieve your pain?  heating pad  hot bath  ice pack  hot shower

If you have tried a brace, does it relieve the pain?  Yes  No

Does a change in shoes or heel height worsen the pain?  Yes  No

Do you feel better when you are moving around?  Yes  No

Do your knees ache or hurt?  Yes  No

Do you have cramps in your:  legs  arms  other? \_\_\_\_\_

Describe the accident:

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

Place of the accident (Address): \_\_\_\_\_

Time Accident Occurred: \_\_\_\_\_ AM PM

Immediately after the accident, how did you feel?

\_\_\_\_\_

Were you unconscious?  Yes  No      Were you in a daze:    Yes  No

Did you go to the hospital?  Yes  No      If yes, how were you transported? \_\_\_\_\_

When did you get to the hospital?  Immediately  1-3 hours later  4-12 hours later  Days later – how many? \_\_\_\_\_

Did ambulance attendants place you in:  Neck Collar?       Splints?       Brace?

Name of hospital: \_\_\_\_\_

Name of doctor you were attended by: \_\_\_\_\_

Were x-rays taken related to this accident?  Yes  No

Was a C.T. scan taken?  Yes  No

List any other lab work or diagnostics related to this accident: \_\_\_\_\_

Were you admitted to the hospital?  Yes  No    If yes, how long were you there? \_\_\_\_\_

What treatment was rendered? \_\_\_\_\_

What recommendations were made? \_\_\_\_\_

Were you advised to:  See your primary physician  See orthopedic specialist  Go to physical therapy  
 Neurologist       Other \_\_\_\_\_

List any other medical facilities you went to because of the accident (immediate care, primary physician, etc):

\_\_\_\_\_

List all previous trauma(s) and date(s) or traumas: \_\_\_\_\_

\_\_\_\_\_

List any other auto / work accident(s) and date(s) and briefly describe accident, injuries and doctors consulted:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_



ProWellness Chiropractic:  
A Creating Wellness  
Center

### Personal Injury Medical Pay

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

SSN \_\_\_\_\_

#### **Information Needed**

Claim Number: \_\_\_\_\_ Date of Accident \_\_\_\_\_

Adjusters Name \_\_\_\_\_

Address to Send Claims to: \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Car Insurance Card (copy) and Policy Number # \_\_\_\_\_

Patient Signature \_\_\_\_\_ date \_\_\_\_\_

Clinical Witness \_\_\_\_\_ date \_\_\_\_\_



11876 Olio Road, Suite 500  
Fishers, IN 46037

## DOCTOR'S LIEN

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

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

Dated: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Dated: \_\_\_\_\_ Attorney Signature: \_\_\_\_\_

Please date, sign and return one copy  
Reply envelope attached  
Keep one copy for your records