Auto Injury Questionnaire

Name_____ Cell # _____
Your Auto Ins. Co._____ Home # _____
Name on policy (if other than yourself)_____

Attorney Information
Name_____ Phone ( ) _____
Address_____ City_____ State____ Zip_____

Nature of Accident
1. Date of accident_____ Time of Day_____
2. Were you: Driver / Passenger / Back Seat Driver Side / Back Seat Passenger Side
3. Does your car have a headrest? Yes / No If Yes, what setting was it at time of accident:
Bottom of neck / Bottom of head / Middle of head
4. Number of people in vehicle:_____ Were you wearing seat belts? Yes / No
5. Were You struck from: Behind / Front / Driver Side / Passenger Side
6. Speed of your car? _____mph Other car_____mph?
7. Were you knocked unconscious? Yes / No If Yes, How Long? _____
8. Were Police Notified? Yes / No
9. Kind of car you were driving: Model_____ Make_____ Year_____
10. How much damage to your car $_____
11. In your own words, please describe the accident:_____
_____
_____
12. Did you have any physical complaints BEFORE THE ACCIDENT? Yes / No
If yes, please describe:_____
13. Please describe how you felt: During the accident_____
Immediately after the accident:_____
Later that day:_____ The next day:_____
14. Where were you taken after the accident?_____
What type of treatment did you receive?_____
15. What other Dr's have treated you since the accident?_____
16. Since the accident, your symptoms are: Improving / Getting Worse / Same
17. Have you lost time from work as a result of this accident? Yes / No
If yes, explain:_____
18. Have you noticed any activity restrictions as a result of this accident? Yes / No
If yes, explain:_____
_____

P.I. PATIENT PROVIDER CONTRACT AND PROMISSORY NOTE

Entered This Day between Dr. Nick Albert **(Hereinafter 'Provider') and**

_____. **(Hereinafter 'Patient'). Provider hereby agrees to establish an active account for the Patient and to provide essential services for the purposes of benefiting and improving Patients current health condition. Patient hereby agrees to pay Provider in full for services performed by Provider. Patient and Provider acknowledge that Patient retains any and all rights of suit to procure payment for and benefit Patient may be entitled.**

In Consideration Of and for Provider rendering essential chiropractic and or medical services to Patient, and for the temporary suspension of any collection activity by Provider by the maintenance of an active account while not receiving payment at the point of service. Patient hereby authorizes and directs the following actions be taken on Patients behalf.

I.PATIENT AUTHORIZATIONS TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Patient by Provider that Patient and Provider are privy of contact, and in lien of Provider sending direct billing to liability insurance carrier Patient authorizes and directs liability insurance company to disclose the settlement status of Patients claim to Provider upon request, including settlement amounts thereof. After Such Time that Patient has settles the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Patient directs the liability carrier to include the name of Provider on any check to Patient Upon such Settlement. In the event payment is made to Patient attorney after settlement of the claim. Patient further authorizes and directs the liability company to issue check to provider for the full amount owed for chiropractic and or medical services rendered to fully satisfy Patients obligation to Provider.

II.PATIENT AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If Patient hires an attorney; Patient acknowledges that Patient is represented

by _____Attorney of Law. Patient and Provider Stipulates, that representation by the above-named attorney prior to settlement, judgment or verdict in the Patients claim. Provider shall have the option to terminate this agreement and immediately collect from Patient the full amount then owed to Provider. Patient directs attorney to disclose to Provider upon request the settlement status and amount of Patient claim to include amount of all outstanding medical bills, dollar amount of any offers and counter offers as well as date and reason of termination or dismissal, patients last address, telephone number and place of employment known to attorney. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement after any settlement, judgment or verdict rendered in patients claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider. This agreement survives this attorney client relationship and all others that may follow in reference to this claim.

III.BINDING ARBITRATION: In the event liability, insurance carrier or Patients attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Patients attorney the likely representative for Patient.

IV.PROMISORY NOTE: For the consideration stated above; Patient promises to pay Provider the full balance in Patients account for services rendered to Patient. Payment shall be due and payable within 30 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by Patient and treated by Provider whichever event occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further Patient agrees to the following:

IN THE EVENT PATIENTS ACCOUNT IS NOT PAID IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENTS ACCOUNT SHALL BECOME DELINQUENT. IF PATIENTS ACCOUNT BECOMES DELINQUENT, PATIENT AGREES TO PAY COLLECTION AGENCY FEES AT 16% OF THE PATIENT ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICE. PATIENT FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFORTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is agreed that, in the event Patient terminates this agreement. Patient shall pay full balance of Patients account within 3 (three) days of termination or the account shall be in default. Patient and Provider acknowledge that this document contains full, final and entire agreement between the parties. There are no other terms to this agreement. Patient has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void it is expressly agreed by the parties that all remaining provision shall remain in full force.

Date of Agreement _____ _____

Patient Signature or Guardian If A Minor

_____ _____

Witness Provider

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness with regard to the various activities listed below. Use the following 1to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.
1 = "I can do it without any difficulty", 2 = "I can do it without much difficulty, despite some pain", 3 = I manage to do it b y myself, despite marked pain", 4 – "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it all because of the pain". Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing.....____	Drying hair.....____	Brushing Teeth.....____	Putting on shoes.....____
Preparing meals...____	Showering.....____	Combing hair.....____	Making bed.....____
Tying shoes.....____	Eating.....____	Doing Laundry....____	Washing hair.....____
Washing face.....	Putting on pants	Cleaning dishes...	Going to toilet.....

Difficulties with Physical Activities

Standing.....____	Walking.....____	Kneeling.....____	Reaching.....____
Twisting left.....____	Twisting right ____	Stooping.....____	Leaning back.....____
Leaning forward..____	Leaning left...____	Leaning Right.....____	Bending left.....____
Bending right.....____	Bending back..____	Bending forward...____	Reclining.....____
Squatting.....____		Standing for long periods.....____	
Sitting for long periods.....____		Walking for long periods.....____	
Kneeling for long periods.....			

Difficulties with Functional Activities

Carrying small objects.....____	Carrying large objects.....____	Carrying brief case.....____
Carrying large purse.....____	Lifting weights off floor.....____	Lifting weights off table...____
Climbing stairs.....____	Climbing inclines.....____	Pushing things while seated____
Pushing things while standing____	Pulling things while seated....____	Pulling things while standing___
Exercising upper body.....____	Exercising lower body.....____	Exercising arms.....____
Exercising legs.....		

Difficulties with Social and Recreational Activities

Bowling...____	Jogging...____	Swimming...____	Ice Skating...____	Competitive sports...____
Dating.....____	Golfing...____	Dancing.....____	Skiing.....____	Roller skating.....____
Hobbies...	Dining Out			

Difficulties with Traveling

Driving in a motor vehicle.....____	Driving for long periods of time.....____
Riding as a passenger.....____	Riding as a passenger on an airplane.....____
Riding as a passenger on a train.....	Riding as a passenger for long periods.....

Use the following 1 to 5 scale to describe the difficulties below:
1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability in this area", 4 = "My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability".

Difficulties with Different Forms of Communication

Concentrating.....____	Hearing.....____	Listening.....____	Speaking.....____	Reading.....____
Writing.....	Using a keyboard.....			

Difficulties with the Senses

Seeing... Hearing... Sense of touch... Tasting... Smelling...

Difficulties with Hand Functions

Grasping....____ Holding....____ Pinching....____ Percussive movements....____
Sensory discrimination.....

Difficulties with Sleep and Sexual Function

Able to have normal, restful nights sleep..... Able to participate in desired sexual activity.....

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above): _____

_____