Personal Injury Form

Patient Information

Today's Date ____________ Date of Injury ____________

First Name ____________ Phone 1 ____________ Marital Status

Last Name ____________ ◯ mobile ◯ home ◯ work ◯ single ◯ married ◯ other

DOB ____________ Phone 2 ____________ Working Status

Sex ◯ male ◯ female ◯ mobile ◯ home ◯ work ◯ employed

SSN ____________ Email ____________ ◯ full-time student

Address ____________ Employer ____________ ◯ part-time student

City ____________ Employer Phone ____________

State ____________ Occupation ____________

Zip Code ____________

Insurance

Primary Insurance	Secondary Insurance
Insurance Name ____________	Insurance Name ____________
Insurance Phone ____________	Insurance Phone ____________
ID # ____________ Group # ____________	ID # ____________ Group # ____________
Insured:First Name ____________	Insured:First Name ____________
Last Name ____________	Last Name ____________
SSN ____________ DOB ____________	SSN ____________ DOB ____________
Copay ______ Deductible ______ Co-Ins ______	Copay ______ Deductible ______ Co-Ins ______
Relationship to Insured ◯ self ◯ spouse ◯ child ◯ other	Relationship to Insured ◯ self ◯ spouse ◯ child ◯ other

Accident History

When did the accident occur? ______ days ago ______ weeks ago ______ years ago other ____________

What time of day did the accident occur? ◯ morning ◯ afternoon ◯ evening ◯ night

Where did the accident occur? ◯ at a commercial location ◯ at a medical facility ◯ at work ◯ at home ◯ during sports ◯ during recreation ◯ other ____________

The injury was a result of? ◯ a fall ◯ a dental accident ◯ a holiday accident ◯ a medical accident ◯ assault ◯ automobile accident ◯ bending ◯ being hit ◯ industrial disease (asbestosis, mesothelioma, etc. ◯ occupational stress/repetitive strain ◯ product defect ◯ sitting ◯ tripping ◯ other ____________

What areas of your body experienced injury? ☐ back (upper) ☐ back (middle) ☐ back (lower) ☐ head ☐ face ☐ jaw ☐ neck ☐ shoulder (left) ☐ shoulder (right) ☐ chest ☐ arm (left) ☐ arm (right) ☐ elbow (left) ☐ elbow (right) ☐ hand (left) ☐ hand (right) ☐ fingers (left hand) ☐ fingers (right hand) ☐ hip (left) ☐ hip (right) ☐ leg (left) ☐ leg (right)

☐ knee (left) ☐ knee (right) ☐ shin (left) ☐ shin (right) ☐ foot (left) ☐ foot (right) ☐ toes (left foot) ☐ toes (right foot)

Did you lose consciousness? ◯ yes ◯ no

If work related, name, address and details of your employer

Did anyone witness the accident? ◯ no ◯ one person ◯ two people ◯ three people ◯ several people

If yes, name, address and details of the witness or witnesses

Who did you report the accident to? ☐ no one ☐ attorney ☐ insurance company ☐ employer ☐ family member(s) ☐ friend(s) ☐ police officer

Name, address and details of who you reported the accident to

Did you retain an attorney? ◯ yes ◯ no

If yes, provide attorney information

Attorney Name ________________

Attorney Address ________________

Attorney Phone ________________

How often have you been receiving treatment? ◯ daily ◯ twice per week ◯ four times per week ◯ five times per week ◯ weekly ◯ bi-weekly ◯ monthly

From whom have you been receiving treatment?

How many days of work have you missed as a result of this accident? ________

Did you go to hospital? ◯ yes ◯ no

Hospital Information

Hospital Name ________________ Hospital Location ________________

Were you hospitalized overnight? ◯ yes ◯ no

Were you prescribed anything? ☐ arm brace ☐ crutches ☐ knee brace ☐ leg brace ☐ muscle relaxers ☐ neck brace ☐ pain medication ☐ topical analgesic ☐ wrist brace ☐ other ________________

What services were performed at the hospital? ☐ none ☐ evaluation by a medical doctor ☐ x-rays ☐ MRI ☐ CT scan ☐ cast ☐ emergency life saving procedures ☐ blood transfusion ☐ stitches ☐ other ________________

What types of diagnostic tests have been performed? ☐ amniocentesis ☐ basic metabolic panel ☐ biopsy ☐ CAT scan ☐ celiac profile ☐ colonoscopy ☐ complete blood count ☐ complete blood count with differential ☐ comprehensive metabolic panel ☐ diagnostic ultrasound ☐ echocardiogram ☐ electrolyte panel ☐ endoscopy ☐ extended cardiac risk profile ☐ hepatic function panel ☐ hepatitis panel, acute ☐ hepatitis panel, chronic ☐ lipid panel ☐ mammogram ☐ MRI ☐ OB profile ☐ PET scan ☐ renal panel ☐ urinalysis ☐ X-ray or X-ray series

Condition

What treatments have you received since the accident? ☐ ice ☐ heat ☐ oral pain medication ☐ topical analgesics
☐ muscle relaxers ☐ wrist brace ☐ knee brace ☐ neck brace ☐ ankle brace ☐ crutches ☐ other ____________

How often have you been receiving treatment? ☐ daily ☐ twice per week ☐ three times per week
☐ four times per week ☐ five times per week ☐ weekly ☐ bi-weekly ☐ monthly

Details of treatment received

Location and provider where previous treatment was received

Are you responding to treatment? ☐ the same ☐ improving ☐ worse ☐ other ____________

How did you feel immediately following the accident? ☐ head pain ☐ neck pain ☐ neck stiffness
☐ jaw/facial pain (TMJ) ☐ shoulder pain ☐ shoulder stiffness ☐ arm pain ☐ chest pain ☐ back pain ☐ low back pain
☐ lower limb pain ☐ back stiffness ☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling
☐ hands/fingers numbness or tingling ☐ upper limb numbness or tingling ☐ cold feet ☐ cold hands ☐ cold sweats
☐ constipation ☐ anxiety ☐ depression ☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented
☐ fainting ☐ fatigue ☐ forgetfulness ☐ impaired concentration ☐ irritability ☐ sensitivity to light
☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ loss of memory ☐ muscle spasms
☐ nauseous ☐ nervousness ☐ pins and needles ☐ restlessness ☐ shortness of breath ☐ sleeping problems
☐ stomach upset ☐ tension ☐ vision blurred ☐ weakness

What symptoms have you experienced since the accident? ☐ head pain ☐ neck pain ☐ neck stiffness
☐ jaw/facial pain (TMJ) ☐ shoulder pain ☐ shoulder stiffness ☐ arm pain ☐ chest pain ☐ back pain ☐ low back pain
☐ lower limb pain ☐ back stiffness ☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling
☐ hands/fingers numbness or tingling ☐ upper limb numbness or tingling ☐ cold feet ☐ cold hands ☐ cold sweats
☐ constipation ☐ anxiety ☐ depression ☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented
☐ fainting ☐ fatigue ☐ forgetfulness ☐ impaired concentration ☐ irritability ☐ sensitivity to light
☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ loss of memory ☐ muscle spasms
☐ nauseous ☐ nervousness ☐ pins and needles ☐ restlessness ☐ shortness of breath ☐ sleeping problems
☐ stomach upset ☐ tension ☐ vision blurred ☐ weakness

Describe the pain? ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating
☐ sharp ☐ shooting ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Does the pain travel anywhere else? ☐ denies radiating pain ☐ TMJ ☐ left TMJ ☐ right TMJ ☐ cranium (headache)
☐ left cranium (headache) ☐ right cranium (headache) ☐ cervical ☐ left upper cervical ☐ right upper cervical
☐ left lower cervical ☐ right lower cervical ☐ upper thoracic ☐ left upper thoracic ☐ right upper thoracic
☐ mid thoracic ☐ left mid thoracic ☐ right mid thoracic ☐ lower thoracic ☐ left lower thoracic ☐ right lower thoracic
☐ anterior rib ☐ left anterior rib ☐ right anterior rib ☐ posterior rib ☐ left posterior rib ☐ right posterior rib
☐ upper lumbar ☐ left upper lumbar ☐ right upper lumbar ☐ lower lumbar ☐ left lower lumbar ☐ right lower lumbar
☐ lumbosacral ☐ right lumbosacral ☐ left lumbosacral ☐ right sacroiliac ☐ left sacroiliac ☐ left anterior shoulder

- [ ] right anterior shoulder
- [ ] left posterior shoulder
- [ ] right posterior shoulder
- [ ] right arm
- [ ] left arm
- [ ] right elbow
- [ ] left elbow
- [ ] right forearm
- [ ] left forearm
- [ ] right wrist
- [ ] left wrist
- [ ] right hand
- [ ] left hand
- [ ] right hip
- [ ] left hip
- [ ] right leg
- [ ] left leg
- [ ] right thigh
- [ ] left thigh
- [ ] right knee
- [ ] left knee
- [ ] right calf
- [ ] left calf
- [ ] right ankle
- [ ] left ankle
- [ ] right foot
- [ ] left foot

Rate your pain on a scale of 0 to 10. *0 being no pain at all and 10 being the worst pain imagineable*

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

Did you receive X-rays for this injury? ◯ yes ◯ no

If yes, by whom? ____________________

If yes, which areas were X-rayed?

- [ ] skull (head)
- [ ] cervical (neck)
- [ ] thoracic (mid back)
- [ ] ribs
- [ ] lumbar (low back)
- [ ] sacral/pelvis
- [ ] chest
- [ ] abdomen
- [ ] left shoulder
- [ ] right shoulder
- [ ] left elbow
- [ ] right elbow
- [ ] left wrist
- [ ] right wrist
- [ ] left hand
- [ ] right hand
- [ ] left hip
- [ ] right hip
- [ ] left upper leg
- [ ] right upper leg
- [ ] left knee
- [ ] right knee
- [ ] left lower leg
- [ ] right lower leg
- [ ] left ankle
- [ ] right ankle
- [ ] left foot
- [ ] right foot

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with ____________________
And assign directly to the above named Chiropractic clinic all insurance benefits, if any, otherwise payable to r
for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

Brett A. Opdahl, D.C. / Opdahl Chiropractic, P.A. may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payme
for services and determining insurance benefits or the benefits payable for related services. This consent will e
when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

______________________________________ Date __________

Signature of Patient, Parent, Guardian or Personal Representative

______________________________________ Date __________

Print Name of Patient, Parent, Guardian or Personal Representative