Heartland Family CHIROPRACTIC LLC

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Personal Injury History

Name:_____ Age:____ Date of Birth:_____ Male/Female
Address:_____ City/state:_____ Zip:_____
SS#:_____ Driver's License #:_____
Your Auto Insurance Company :_____ Phone #:_____
Name of Agent and/or Adjustor:_____ Claim #:_____
Do you have an Attorney? Y N Name: _____Phone #:_____
3rd Party Auto Insurance Company:_____ Phone #:_____
Name of Agent and/or Adjustor:_____ Claim #:_____

Internal Office Use:
☐ Claim # verified

Adustor Name & Ph#:
Claims Mailing address:

SYMPTOMS:

Did you hit your head, arm, chest, leg, etc? Explain:_____

_____

Were you conscious after accident? Y N Do you remember the impact? Y N
Did you go to the hospital after the accident?_____
Names of any treating Doctors since accident:_____
What care were you given since accident?_____
How did you feel after the accident? Where was the pain?_____

_____

Does it bother you to ride in a car now as passenger or driver? Y N

ACCIDENT HISTORY:

Date of Accident:_____ Time of Accident:_____ City of Accident:_____
Did the police arrive? Y N Please bring us a copy of the accident report.
State how the accident happened:_____

_____

_____

What type of vehicle were you in? Make:_____ Year:_____
Were you driving? Y N Was it your car? Y N If not, whose car was it?_____
Were you passenger? Y N Were you rotated in your seat? Y N Were you reclined? Y N
Were other people in the car? Y N
Names, phone numbers, and addresses:_____

_____

Were they injured? Y N If yes, please explain: _____

_____

Were you wearing your seat belt? Y N Shoulder harness on? Y N Headrest: high or low

What were the weather conditions?_____Traffic Conditions?_____

Type of road: single lane highway/freeway gravel road Posted speed limit: _____

Did it happen at a: stop sign traffic light intersection on road How fast were you going? _____

Was your car hit from the: front back left side right side

Did your vehicle hit something? Y N If yes : another car sign/pole tree bridge embankment

If you struck another car, did you strike it on the: front back side

Did your vehicle go off the road? Y N If yes : into ditch into embankment How Deep?_____

State any strange events that happened during or immediately after the accident:

_____

_____

In what condition was the vehicle prior to the accident?_____

What was the damage to the vehicle?

Inside:_____ Outside:_____

If there was another vehicle involved, was it a: car truck motorcycle SUV Other:_____

What was the damage to the other vehicle?

Inside:_____Outside:_____

Do you have pictures of the automobile? Y N

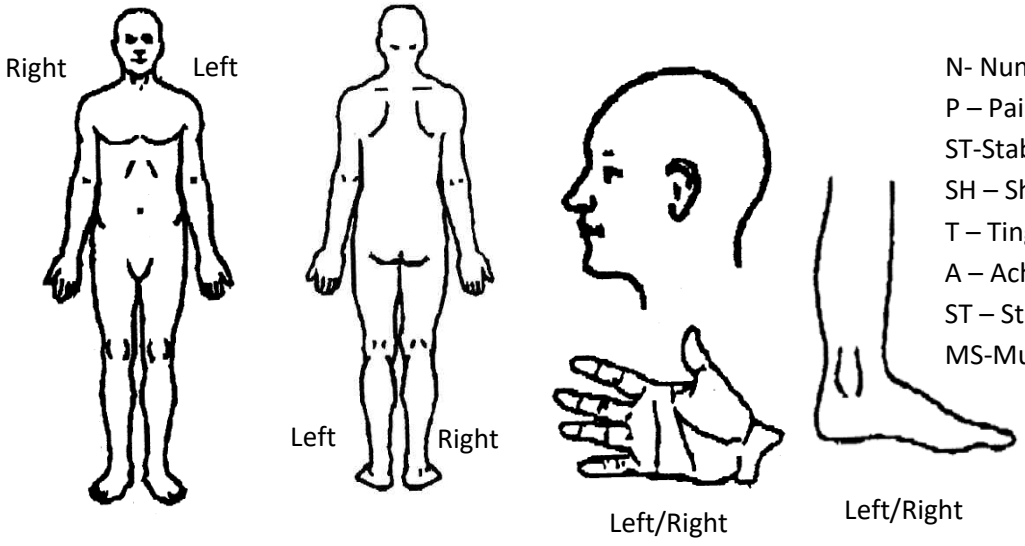
Was an accident report made? Y N Police of City:_____County:_____ State: ___

Who was ticketed?_____ For what? _____

Have you had any time loss from work? Y N If yes, from _____ to _____

INJURY DETAIL:

Please circle area(s) of injury and describe your symptoms using the codes listed below.



N- Numbness	TH-Throbbing
P – Pain	SW-Swelling
ST-Stabbing	D – Dull
SH – Sharp	SO-Shooting
T – Tingling	B-Burning
A – Ache	C-Cramps
ST – Stiffness	S – Soreness
MS-Muscle Spasm	O-Other

Updated September 2015

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1._____
Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #2._____
Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #3._____
Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

I attest that the above given information is complete and accurate to the best of my knowledge.
Signature:_____ Date:_____

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