Family Chiropractic Center of Bayonne

Noah De Koyer, D.C.
120 Lefante Way ● Bayonne ● New Jersey ● 07002
Phone (201) 437-0033 ● Fax (201) 858-4049
www. fccofbayonne.com

PERSONAL INJURY QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

PATIENT/INSURED'S INFORMATION

Patient Last Name	First Name	M.I.	Date of Birth	Social Security Number	☐ M ☐ F
Insured's Last Name	First Name	M.I.	Date of Birth	Social Security Number	☐ M ☐ F

Insured's Address	City	State	Zip Code	Phone Number

INSURANCE COMPANY

Primary Insurance Carrier	Policy #		Claim#	
Address	City	State	Zip Code	Ins. Co. Phone Number
Secondary Insurance Carrier	Policy #		Claim#	
Address	City	State	Zip Code	Ins. Co. Phone Number

ATTORNEY INFORMATION

Attorney Name	Phone Number	Fax Number	
Address	City	State	Zip Code

ACCIDENT INFORMATION

What type of Injury? ☐ Auto Accident ☐ Work Comp. ☐ Other	Date of Injury:	Time of Injury: ☐ AM ☐ PM	Date of First Treatment:

HISTORY OF INJURY:

In your own words, please briefly describe your how the accident happened:

_____
_____
_____
_____
_____
_____

PREVIOUS CONDITIONS AND TREATMENT:

In your own words, please list any previous accidents, injuries, or conditions which may have contributed to your present complaints: _____
_____
_____
_____
_____

PLEASE TURN OVER

Auto Accident Info

- ***What was your position in the vehicle?***
  □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian (not in car)
- ***What type of vehicle were you driving or riding in?***
  □ Compact Car □ Mid Size Car □ Full Size Car □ Compact Truck
  □ Full Truck □ Mini Van □ Full Size Van □ Small SUV
  □ Lg. SUV □ Motorcycle □ Motor Home □ Bicycle
- ***Make and model of vehicle:_____***
- ***What was <u>your</u> vehicle doing just prior to the accident?***
  □ Stopped at a stop light □ Slowing down to a stop
  □ At a complete stop □ Increasing speed
  □ Merging into traffic □ Changing Lanes □ Other_____
- ***<u>You</u> were traveling at an approximate speed of _____mph.***
- ***Who hit who?***
  □ You were struck by another car □ Struck another car
  □ You struck a stationary object □ Other_____
- ***How were the weather conditions?***
  □ Sunny □ Hazy □ Rain □ Sleet
  □ Snow □ Fog □ Other_____
- ***What was <u>your</u> vehicle's point of impact?*** *(mark all that apply)*
  □ Front □ Rear □ Right Side □ Left Side
  □ Right Front □ Left Front □ Right Rear □ Left Rear
- ***What was <u>the other</u> vehicle doing just prior to the accident?***
  □ Stopped at a stop light □ Slowing down to a stop
  □ At a complete stop □ Increasing speed
  □ Merging into traffic □ Changing Lanes □ Other_____
- ***The <u>other vehicle</u> was traveling at an approximate speed of _____mph.***
- ***What was <u>the other</u> vehicle's point of impact?*** *(mark all that apply)*
  □ Front □ Rear □ Right Side □ Left Side
  □ Right Front □ Left Front □ Right Rear □ Left Rear
- ***Were <u>you</u> wearing seat restraints?***
  □ Full lap and shoulder restraint □ Lap restraint only
  □ Shoulder restraint only □ Was not wearing a restraint
- ***What position were <u>your</u> vehicle's head rests in?***
  □ Lowest position □ Middle position
  □ Highest position □ No head rest in vehicle
- ***Did <u>your</u> vehicle's air bags deploy?***
  □ Yes □ No □ Vehicle not equipped with air bags
- ***Were <u>you</u> prepared for the impact?***
  □ Came as a complete surprise □ Aware and braced for the collision
  □ Aware but not braced for the collision □ Other_____
- ***What position was <u>your</u> head and neck in prior to the impact?***
  □ Straight forward □ Rotated to the left □ Rotated to the right
  □ Turned around □ Turned around □ Toward the rear view mirror
- ***What happened to <u>your</u> body at the moment of impact?***
  □ Body was tensed for impact □ Body whipped forward/backward
  □ Body torqued and twisted □ Body was thrown over seat
  □ Body was thrown from vehicle □ Body was pinned in vehicle
  □ Body was thrown from side to side □ Body was cut and bruised
- ***What was <u>your</u> mental/emotional state immediately following?***
  □ Unconscious □ Shaken up
  □ Disoriented □ Shaken up & Disoriented
- ***Did <u>you</u> receive medical attention at the scene of the accident?***
  □ Yes □ No
- ***Where did <u>you</u> go immediately following the accident?***
  □ Home □ Personal Doctor □ This office □ Resumed daily activities
  □ Hospital (if selected, please answer next question)
- ***How did you get to the hospital?***
  □ Ambulance □ Friend/Family member □ Other _____
- ***Do you have hospital records?***
  □ Yes □ No
- ***Do you work:***
  □ Full time □ Part time □ Student □ Retired
- ***How many days were missed from work and/or school following the accident? _____***
- ***To your best knowledge, please list any part of your body that may have struck any part of the vehicle.*** *(For example: Right arm hit dashboard)*_____
  _____
  _____
  _____

Workers Comp Info

<u>If your injury involved LIFTING, complete this section:</u>

- ***From where were you lifting an object?***
  □ Ground level □ A surface below ground level
  □ A surface 1 to 3 feet high □ A surface 3 to 5 feet high
- ***How many pounds was the object you were lifting?***
  □ 1 to 5 pounds □ 5 to 10 pounds □ 10 to 20 pounds
  □ 20 to 40 pounds □ 40 to 60 pounds □ Over 60 pounds
- ***What position were you in while lifting the object?***
  □ Back was upright and straight □ Bent over at the waist
  □ Twisted to the left side □ Twisted to the right side
- ***What type of pain did you feel immediately after the injury?***
  □ Gripping pain □ Sharp pain □ Dull pain
  □ Aches □ Popping feeling □ Paralysis

<u>If your injury involved Falling, complete this section:</u>

- ***From where did you fall at work?***
  □ Onto the ground while walking □ Onto the ground while running
  □ From 1 to 3 feet high □ From 3 to 5 feet high
  □ From 5 to 8 feet high □ From higher than 8 feet
- ***What part of your body did you land on?***
  □ Head □ Neck □ Right Shoulder □ Left Shoulder
  □ Right Arm □ Left Arm □ Right Hand □ Left Hand
  □ Back □ Right Buttock □ Left Buttock □ Tail Bone
  □ Right Hip □ Left Hip □ Right Leg □ Left Leg
  □ Right Knee □ Left Knee □ Right Foot □ Left Foot
- ***What other areas of your body were affected by you fall?***
  □ Head □ Neck □ Right Shoulder □ Left Shoulder
  □ Right Arm □ Left Arm □ Right Hand □ Left Hand
  □ Back □ Right Buttock □ Left Buttock □ Tail Bone
  □ Right Hip □ Left Hip □ Right Leg □ Left Leg
  □ Right Knee □ Left Knee □ Right Foot □ Left Foot

<u>Other work related injuries:</u>

□ Raised up from bending over □ Twisted at the waist
□ Wrist injury from repetitive use □ Wrist injury from pulling
(Please describe all injuries in your own words on page 1 of this form)

<u>Job analysis information:</u>

- ***What regular activities do you perform at work?***
  (Please mark all that apply)
  □ Sitting □ Standing □ Walking
  □ Running □ Driving □ Lifting
  □ Bending/Stooping □ Squatting □ Crawling
  □ Climbing □ Crouching □ Kneeling
  □ Reach above Shoulders □ Pushing/Pulling
  □ Maintain awkward position
- ***How much do you regularly lift at work?***
  □ Little to none □ 1 to 10 Lbs □ 10 to 20 Lbs □ 20 to 40 Lbs
  □ 40 to 60 Lbs □ 60 to 80 Lbs □ 80 to 100 Lbs □ Over 100 Lbs
- ***Do you regularly bend over while lifting?*** □ Yes □ No
- ***Are your hands subject to any of the below repetitive movements?***
  □ Light grasping (left hand/Right Hand/Both) (*Please circle one)*
  □ Firm grasping (left hand/Right Hand/Both) (*Please circle one)*
  □ Typing □ Using a computer mouse
- ***How many hours do you regularly perform the below activities?***
  Sitting: □ 1-2 hours □ 2-4 hours □ 4-6 hours □ 6-8 hours
  Standing: □ 1-2 hours □ 2-4 hours □ 4-6 hours □ 6-8 hours
  Walking: □ 1-2 hours □ 2-4 hours □ 4-6 hours □ 6-8 hours
  Lifting: □ 1-2 hours □ 2-4 hours □ 4-6 hours □ 6-8 hours

Family Chiropractic Center of Bayonne's Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Family Chiropractic Center of Bayonne** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of **Family Chiropractic Center of Bayonne**. I understand that diagnosis or treatment of me by the doctors and practitioners of the **Family Chiropractic Center of Bayonne** may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Family Chiropractic Center of Bayonne** is not required to agree to the restrictions that I may request. However, if **Family Chiropractic Center of Bayonne** agrees to a restriction that I request, the restriction is binding on **Family Chiropractic Center of Bayonne** and its doctors and practitioners. I have the right to revoke this consent, in writing, at any time, except to the extent that the doctors and practitioners of the **Family Chiropractic Center of Bayonne** have taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review **Family Chiropractic Center of Bayonne's** Notice of Privacy Practices prior to signing this document. The **Family Chiropractic Center of Bayonne's** Notice of Privacy Practices is available at the front desk. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the **Family Chiropractic Center of Bayonne**. The Notice of Privacy Practices for **Family Chiropractic Center of Bayonne** is also provided on the wall in the waiting area and on **Family Chiropractic Center of Bayonne's** website at www.fccofbayonne. This Notice of Privacy Practices also describes my rights and the **Family Chiropractic Center of Bayonne's** duty with respect to my protected health information. **Family Chiropractic Center of Bayonne** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Family Chiropractic Center of Bayonne's** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority