Delaware Valley
Chiropractic & Rehabilitation
MEDICAL | CHIROPRACTIC | REHABILITATION
ORTHOPEDIC | PAIN MANAGEMENT

Call Now!
Speak Directly to a Doctor
610-376-1881
231 N. 5th Street, Reading, PA 19601

# Accident Questionnaire

Please answer all completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and you answers will help us determine if chiropractic can help you. If we do not sincerely believe you condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex____Marital Status_____Date of Birth _____ Social Sec#_____

Address _____ City_____ State_____ Zip Code_____

Cellphone Number _____ Home Phone Number_____

Business Phone _____ Who referred you to our office?_____

Please explain in detail how your accident happened _____

_____

_____

What was the time and date of present injury?_____

Where did you feel pain immediately after the accident?_____

Were you knocked unconscious? Yes ___ No___ If yes, for how long?_____

List extent of injuries as you know them:_____

Is there a possibility you are pregnant? _____

Check symptoms you have notice since the accident:

Headache___ Dizziness___ Depression___ Fatigue___ Upset Stomach___ Light Bothers Eyes___ Buzzing In Ears___

Diarrhea___ Head Seems Heavy___ Loss of Memory___ Feet Cold___ Neck Pain___ Pins and Needles in Arms___

Ears Ring___ Hands Cold___ Fainting___ Sleeping Problems___ Loss of Balance___ Back Pain___ Chest Pain___

Pins and Needles in Legs___ Constipation___ Tension___ Numbness in Fingers___ Numbness in Toes___

Shortness of Breath___

Symptoms other than above: _____

Where were you taken after the accident?_____

Hospitalized? Yes ___ No___ If yes, admitted?_____ How long? _____

What treatment was given?_____

What was the doctor's name? _____ Have you ever had any complaints in involved area before?_____ If so what were the complaints?_____

Have you ever been in an accident before?_____ If so, When?_____If yes, please describe:

_____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No

A. Last day worked:

B. Type of employment:

C. Are you being compensated for time lost from work? ☐ Yes ☐ No

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving ☐ Getting Worse ☐ Same

Name of your car insurance company:

Policy No: Claim No:

Name of your car insurance adjuster:

Have you retained an attorney? ☐ Yes ☐ No

If so, name and address

Number of people in your vehicle?

You were ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Using Seatbelts

Were Police notified? ☐ Yes ☐ No

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature: Date:

NAME_____ DATE:_____

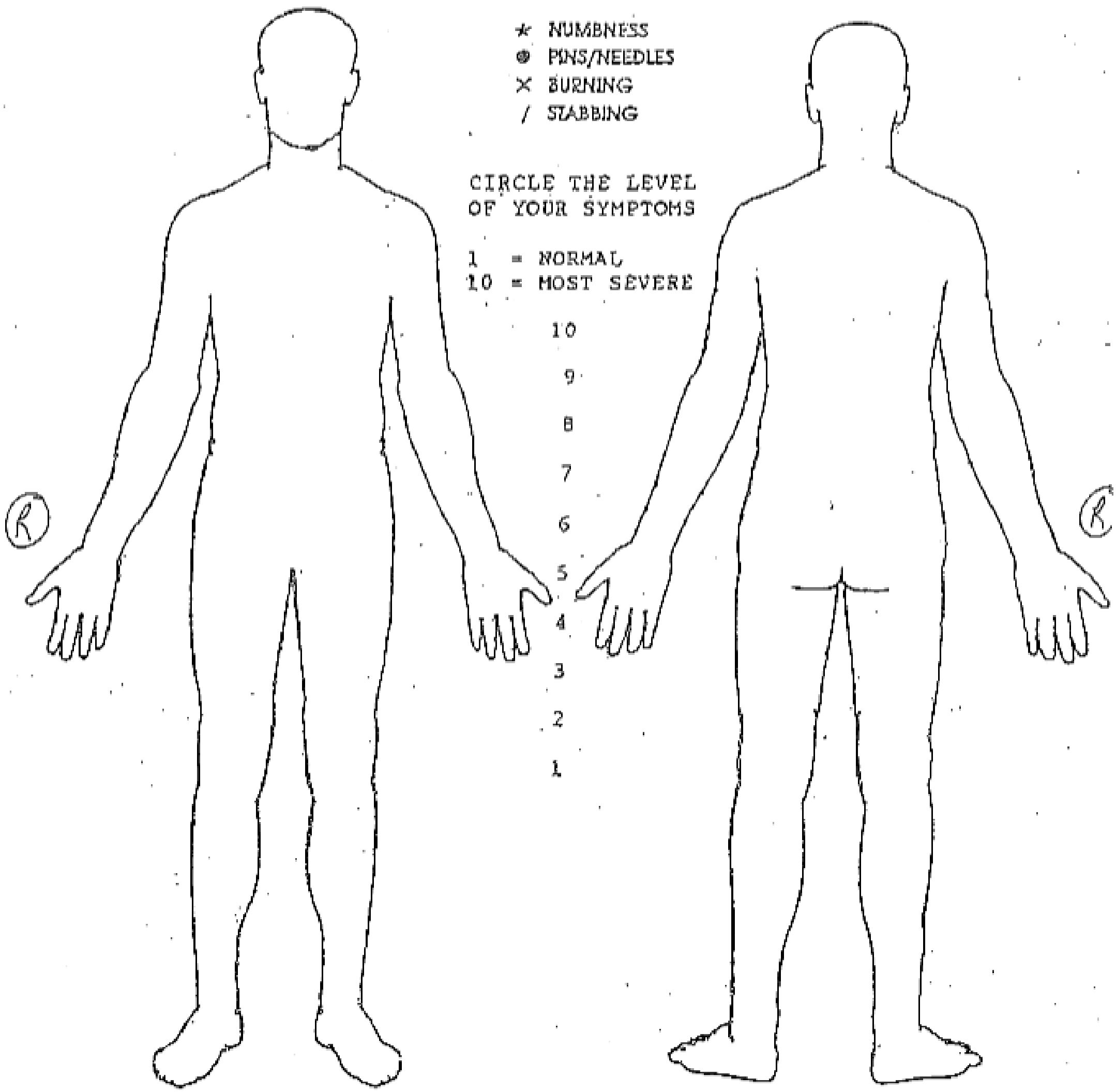
Please mark the areas on your body where you feel the following sensations, using the symbols below:

* NUMBNESS
⊛ PINS/NEEDLES
× BURNING
/ STABBING

CIRCLE THE LEVEL OF YOUR SYMPTOMS

1 = NORMAL
10 = MOST SEVERE

10
9
8
7
6
5
4
3
2
1




FRONT BACK

PATIENT SIGNATURE: _____

# AFFIDAVIT OF FRAUD

I _____

DO HEREBY DEPOSE AND STATE THAT I WAS INVOLVED IN AN ACCIDENT ON:

_____

AT:

_____

AND THAT I SUSTAINED INJURIES IN THE ABOVE ACCIDENT.

ALL THE INFORMATION AND DOCUMENTATION THAT I GAVE TO STUART K. HIMMELSTEIN, D.C., PERTAINING TO THIS ACCIDENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

THE FACTS THAT ARE SETFORTH IN THIS AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF. THE UNDERSIGNED UNDERSTANDS THAT THE STATEMENTS ARE MADE UNDER PENALTY OF PERJURY AND ARE SUBJECTED TO THE PENALTIES OF 18 P.S. @ 4909 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

_____

_____

WITNESS

# INSURANCE
# TODAY'S NEW PATIENT

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK #: _____

SOCIAL SECURITY: _____ DOA: _____

DOI: _____ TYPE OF ACCIDENT: _____

ATTORNEY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT OR PARALEGAL: _____

PHONE #: _____ FAX: _____

INSURANCE CO.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ FAX: _____

POLICY# _____ CLAIM # _____

ADJUSTER _____ EXT: _____

INSURED NAME _____

SECONDARY INSURANCE/ PERSONAL CHOICE –KEYSTONE-AETNA-CIGNA-MEDICARE-UNITED HEALTCARE-INDEPENDENCE B/C-OTHER
YES____ NO_____

SPOKE TO: _____ CONFIRMED BY: _____

DATE CONFIRMED: _____

# Records Release Authorization

To: _____

_____

I, _____ hereby request that you release to:
(Patient's Name or Guardian)

Stuart K. Himmelstein, D.C.
2981 Grant Avenue
Philadelphia, Pa 19114
Tel: 215-632-3074

A report of diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from_____to_____

_____
(Date of Request)

_____
(Patient's Signature)

_____
(Address)

_____
(City, State, Zip Code)