

Weitz Sports Chiropractic and Nutrition

Ben Weitz D.C. C.C.S.P.

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Santa Monica, CA 90404

310-395-3111

Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

Other Doctors Seen For This Condition: \_\_\_\_\_

Purpose of This Appointment: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to 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 to me will immediately be due and payable.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# WEITZ SPORTS CHIROPRACTIC PERSONAL INJURY QUESTIONNAIRE

## INFORMATION ABOUT YOU

Name: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: F \_\_ M \_\_ S/S #: \_\_\_\_\_  
Marital Status: Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_  
Profession: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

## INFORMATION ABOUT YOUR AUTO INSURANCE

Your Automobile Insurance Co: \_\_\_\_\_  
Agent's Name: \_\_\_\_\_ Agent's Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Responsible Party's Name (if not self): \_\_\_\_\_  
Responsible Party's Automobile Insurance Co.: \_\_\_\_\_  
Agent's Name: \_\_\_\_\_ Agent's Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Responsible Party's Policy #: \_\_\_\_\_ & Claim #: \_\_\_\_\_

## INFORMATION ABOUT YOUR ATTORNEY

Name: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Were there any witnesses? Yes\_\_ No\_\_ If so, Name: \_\_\_\_\_

## INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Day: \_\_\_\_\_  
Street where accident occurred: \_\_\_\_\_ City \_\_\_\_\_
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back seat
3. Number of people in your vehicle: \_\_\_\_\_ Were you wearing a seat belt? Yes\_\_ No\_\_
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
5. What direction was the other vehicle heading? ( ) North ( ) South ( ) East ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car: \_\_\_\_\_mph Other car: \_\_\_\_\_mph

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

8. Were you knocked unconscious? Yes \_\_\_\_ No \_\_\_\_ If yes, for how long? \_\_\_\_\_

9. Were the police notified? Yes \_\_\_\_ No \_\_\_\_ Was there a police report? Yes \_\_\_\_ No \_\_\_\_

10. Were you aware of the impending collision? Yes \_\_\_\_ No \_\_\_\_

11. In your own words, please describe the accident:

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12. Have you ever been involved in an accident before? Yes \_\_\_\_ No \_\_\_\_

If yes, describe, including date(s) and type (s) of accidents as well as injury received:

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13. Where were you taken after your current accident? \_\_\_\_\_

If a hospital, name of hospital: \_\_\_\_\_

14. Have you been treated by another doctor since the accident? Yes \_\_\_\_ No \_\_\_\_

If yes, name/telephone: \_\_\_\_\_

15. Have you had X-Rays, MRI, CT Scan? Yes ( ) No ( ) What areas were taken: \_\_\_\_\_

16. Did you have any physical complaints BEFORE THE ACCIDENT? Yes \_\_\_\_ No \_\_\_\_

If yes, describe: \_\_\_\_\_

17. Do you have any congenital (from birth) factors which relate to this problem? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe: \_\_\_\_\_

18. Please describe how you felt:

DURING the accident: \_\_\_\_\_

IMMEDIATELY AFTER the accident: \_\_\_\_\_

LATER THAT DAY: \_\_\_\_\_

THE NEXT DAY: \_\_\_\_\_

19. What describe your PRESENT complaints and symptoms?

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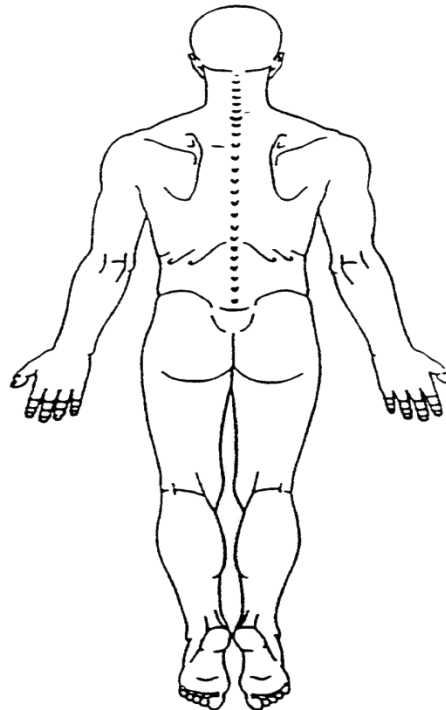
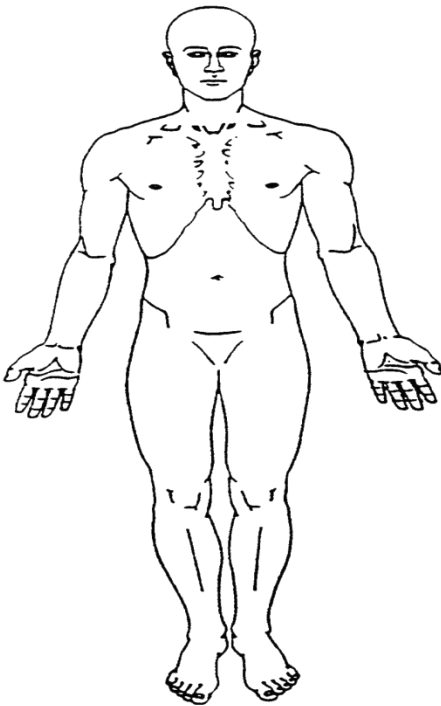
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Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please rate your current level of pain (how you feel today):**

**0 (NO PAIN)    1    2    3    4    5    6    7    8    9    10 (UNBEARABLE PAIN)**

Please mark an X on the picture where you have PAIN or other symptoms:



20: CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Headache         | <input type="checkbox"/> Anxious/Depression        | <input type="checkbox"/> Hip pain            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Dizziness/Loss of balance | <input type="checkbox"/> Knee pain           | <input type="checkbox"/> Fatigue             |
| <input type="checkbox"/> Neck Stiff       | <input type="checkbox"/> Tingling/Numbness Arm     | <input type="checkbox"/> Foot pain           | <input type="checkbox"/> Light sensitivity   |
| <input type="checkbox"/> Sleeping Problem | <input type="checkbox"/> Tingling/Numbness Leg     | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Loss of memory      |
| <input type="checkbox"/> Back pain        | <input type="checkbox"/> Nervousness               | <input type="checkbox"/> Rib pain            | <input type="checkbox"/> Ears ringing        |
| <input type="checkbox"/> Shoulder pain    | <input type="checkbox"/> Tension                   | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Upset stomach       |
| <input type="checkbox"/> Arm pain         | <input type="checkbox"/> Hand pain                 | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Loss of smell/taste |

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Symptoms other than above: \_\_\_\_\_

**Please circle any of the following that apply:**

21. How often are your symptoms present? Constantly    Frequently    Occasionally    Intermittently

22. Describe your current pain/symptoms:

Sharp/Stabbing    Throbbing    Aches    Dull    Soreness    Weakness    Numbness  
Shooting    Gripping    Burning    Tingling    Other: \_\_\_\_\_

23. Since pain began, is your problem: Improving    Getting Worse    No change

24. What makes the problem better?

Nothing    Lying Down    Walking    Standing    Sitting    Movement    Exercise  
Inactivity/Rest    Ice    Heat    Medications    Stretching    Other: \_\_\_\_\_

25. What makes the problem worse?

Nothing    Lying Down    Walking    Standing    Sitting    Movement    Exercise  
Inactivity/Rest    Your Mother in Law    Other: \_\_\_\_\_

26. Have you lost time from work as a result of this accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Last day worked: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of employment: \_\_\_\_\_

Present salary: \_\_\_\_\_ Are you being compensated for time lost from work?: ( ) Y ( ) N

27. Do you notice any activity restrictions as a result of this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

28. Do you have any previous illnesses which relate to this case? Yes \_\_\_\_\_ No \_\_\_\_\_

29. Family History: Cancer    Diabetes    High Blood Pressure    Heart Problems/Stroke    Osteoporosis

30. Are you currently taking any medications for the pain? If yes, then please list: \_\_\_\_\_

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_