Reza ChiroMed Center

Pary Rashidain, D.C., MSc, MA, BA

1009 Wilshire Blvd, Suite 225

Santa Monica, CA 90401

Tel: 4242529179

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: _____

Reza ChiroMed PERSONAL INJURY QUESTIONAIRE

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 impeding collision? Yes ____ No ____
11. In your own words, please describe the accident:

_____

_____

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:

_____

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?

_____

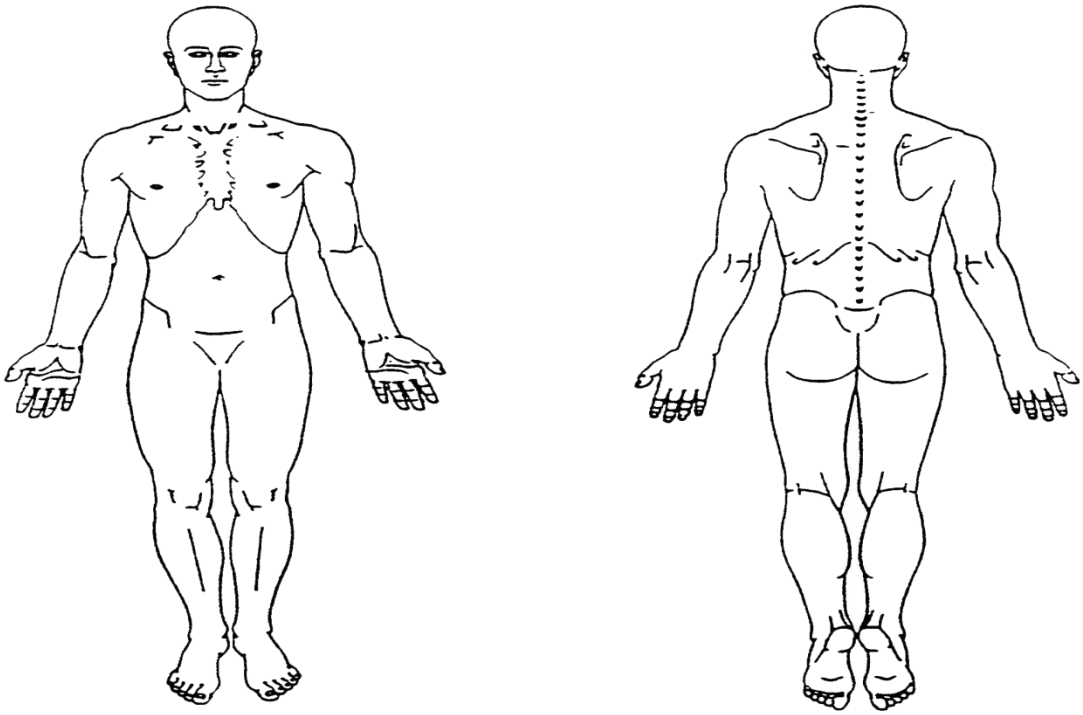
_____

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:

( ) Headache ( ) Anxious/Depression ( ) Hip pain ( ) Shortness of breath

( ) Neck pain ( ) Dizziness/Loss of balance ( ) Knee pain ( ) Fatigue

( ) Neck Stiff	( )Tingling/Numbness Arm	( ) Foot pain	( ) Light sensitivity
( ) Sleeping Problem	( )Tingling/Numbness Leg	( ) Chest pain	( ) Loss of memory
( ) Back pain	( ) Nervousness	( ) Rib pain	( ) Ears ringing
( ) Shoulder pain	( ) Tension	( ) Numbness in fingers	( ) Upset stomach
( ) Arm pain	( ) Hand pain	( ) Numbness in toes	( ) 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: _____