Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

PERSONAL INJURY FORM

Patient Name ____________________ Today's Date ____________

CLAIM FILING INFORMATION (Responsible party's insurance carrier information)

Insurance Co. ____________ Policy Holder's Name ____________ Policy # ____________
Agent Name ____________ Agent Phone# ____________ **Claim #** ____________
Agent Address ____________ City ____________ State ______ Zip ______

YOUR INSURANCE COMPANY INFORMATION

Insurance Co. ____________ Policy Holder's Name ____________ Policy # ____________
Agent Name ____________ Agent Phone # ____________ **Claim #** ____________
Agent Address ____________ City ____________ State ______ Zip ______

ATTORNEY INFORMATION (If applicable)

Attorney Name ____________ Attorney Phone # ____________ **File #** ____________
Attorney Address ____________ City ____________ State ______ Zip ______

MECHANISM OF INJURY

Date of Injury ____/____/______ Hour of Accident ______ ☐ AM ☐ PM Place of Injury ____________

Was the accident reported to anyone? ☐ No ☐ Yes Name and title of the person you reported to ____________

Please fully describe how the accident happened ____________

____

Have you lost time from work because of this accident? ☐ No ☐ Yes If yes, how much time? ____________

Other doctors seen for this condition (Doctor's name) ____________

What diagnosis were you given? ____________

What treatment was given? (Check all that apply) ☐ None ☐ X-rays ☐ Pain Medication ☐ Stitches ☐ Muscle Relaxants ☐ Bandaged

☐ Cervical Collar ☐ Physical Therapy ☐ Instructed Regarding Concussion ☐ Instructed Regarding Sprains & Strains

☐ Instructed to Call an Orthopedist ☐ Instructed to Call a Private Physician ☐ Referred to This Office ☐ Other ____________

Did you have any previous Personal Injury Claims? ☐ No ☐ Yes If yes, date(s) of previous injuries? ____________

Describe previous Personal Injuries ____________

Have you ever received Chiropractic Care? ☐ No ☐ Yes If yes, what was the name of the Chiropractic Physician? ____________

What was the approximate date of your last visit? ____________ What were you being treated for? ____________

DUTIES UNDER DURESS SUMMARY

Check the day-to-day living **duties that are difficult or painful** for you to do as a result of your injuries from this personal injury.

What is your job description? ____________ Check all Activities that you have difficulty with at work below:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Other ____________

Check all Activities that you have difficulty with doing School/Studies:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Studying ☐ Other ____________

Check all Activities that you have difficulty with doing Domestic Duties:

☐ Vacuuming ☐ Cleaning ☐ Preparing Meals ☐ Taking Care of Kids ☐ Other ____________

Check all Activities that you have difficulty with doing Household Duties:

☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash ☐ Other ____________

LOSS OF ENJOYMENT SUMMARY

Check all activities as they relate to your lifestyle, work and daily activities that you normally would be enjoying, but are currently **not enjoying** or have had to reduce the time you are capable of experiencing them as a result of this personal injury.

What is your job description? ____________ Check all Activities that you have difficulty with at work:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Other ____________

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LOSS OF ENJOYMENT SUMMARY Continued…

Check all Activities that you have difficulty with doing School/Studies:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Studying ☐ Other ___________________

Check all Activities that you have difficulty with doing Domestic Duties:

☐ Vacuuming ☐ Cleaning ☐ Preparing Meals ☐ Taking Care of Kids ☐ Other ___________________

Check all Activities that you have difficulty with doing Household Duties:

☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash ☐ Other ___________________

Check and name all Sports Activities that are having difficulty with as a result of your injuries from this personal injury.

☐ Social ____________________ ☐ Competitive ____________________ ☐ Regional ____________________ ☐Other ____________________

My signature below certifies that the above information is true and complete to the best of my knowledge.

______________________________ ______________________________ ______________
Name of Patient (Printed) Signature of Patient Date

______________________________ ______________________________
(Signature of Legal Representative if patient a minor) Relationship (e.g. Guardian or Parent if patient a minor)