Caledonia Chiropractic Clinic
5401 Douglas Ave, Suite A
Racine, WI 53402

PERSONAL INJURY QUESTIONNAIRE

Phone: 262.681.8829
Fax: 353.681.8830
drschneider@tds.net

Name _____ Phone ( ) _____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ SSN _____

Employer's Name _____ Employer's Address _____

Your Car Ins Co _____ Claim # _____ Agent's Name _____

Name on Policy (if other than self) _____ Ins Phone ( ) _____

Responsible Party's Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Address _____

Were there any witnesses? ( ) No ( ) Yes Name(s) _____

ATTORNEY INFORMATION

Law Office _____ Attorney Name _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing a seat belt? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car _____ mph. Approximate speed of other car _____ mph.
8. Were you knocked unconscious? ( ) Yes ( ) No
9. Were police notified? ( ) Yes ( ) No 9a. Do you have an Accident Report? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

    _____

    _____

    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) No ( ) Yes If yes, please describe in detail: _____

    _____

    _____

    _____

12. Please describe how you felt:
    a) DURING the accident: _____
    b) IMMEDIATELY AFTER the accident: _____
    c) LATER THAT DAY: _____
    d) THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) No ( ) Yes If yes, please describe: _____

_____

15. Do you have any previous illnesses which relate to this case? ( ) No ( ) Yes If yes, please describe: _____

_____

16. Have you ever been involved in an accident before? ( ) No ( ) Yes If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

17. Where were you taken after this accident? _____

18. Have you been treated by another doctor/facility since this accident? ( ) No ( ) Yes If yes, please list the doctor's/facility's name and address: _____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Hands Cold
( ) Neck Stiff	( ) Dizziness	( ) Fatigue	( ) Loss of Balance	( ) Stomach Upset
( ) Sleeping Problems	( ) Head Seems too Heavy	( ) Depression	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Pins & Needles in Arms	( ) Lights Bother Eyes	( ) Loss of Smell	( ) Cold Sweats
( ) Nervousness	( ) Pins & Needles in Legs	( ) Loss of Memory	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Numbness in Fingers	( ) Ears Ring	( ) Diarrhea	( ) _____

** Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) No ( ) Yes If yes, please complete these questions:
    a. Last Day Worked: _____
    b. Type of Employment: _____
    c. Present Salary: _____
    d. Are you being compensated for time lost from work? ( ) No ( ) Yes If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) No ( ) Yes If yes, please describe, in detail: _____

_____

_____

23. Other pertinent information: _____

_____

_____

_____ _____

Patient's Signature **Date**

CALEDONIA CHIROPRACTIC CLINIC

5401 Douglas Ave, Suite A.
Racine, WI 53402
Phone: 262.681.8829
Fax: 262.681.8830

NOTICE OF DOCTOR'S LIEN/ASSIGNMENT OF BENEFITS

Patient:_____ Date of Accident:_____

I do hereby authorize Caledonia Chiropractic Clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved. I also acknowledge that such doctor or his/her representative(s) may provide further consideration in exchange for this lien/assignment; including deposition testimony, trial testimony, and requested report(s).

I hereby authorize and direct you, my current and any successor attorney(s); together with any responsible insurance company, to pay directly to Caledonia Chiropractic Clinic such total sums as are currently due and may become due and owing him/her in the future for all chiropractic and related services rendered me both by reason of this accident and by reason of any other bills that are due his office and to further withhold such total sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor for such total sums. I hereby further give a lien or assignment of my potential benefits on my pending/prospective case to said doctor against any and all insurance benefits, referenced below, and proceeds of my settlement, judgment, court order or verdict which may be paid to you, my attorney, and/or myself as a result of the injuries or illness for which I have been or will be treated from a chiropractic scope of care perspective in connection with such accident; including any unpaid services for chiropractic care provided prior to such accident.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered me and that this agreement is made for said doctor's additional protection and in consideration of his awaiting payment and other services provided by him, as referenced above. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee and that my doctor may take appropriate and timely action to enforce payment against me for all such outstanding chiropractic bills.

I agree to promptly notify said doctor prior to any change or addition of attorney(s) used by me in connection with this accident, and I instruct my present attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I further acknowledge and agree that this executed lien/assignment shall be binding upon any subsequent and/or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney.

I request that my attorney(s) and any applicable insurance company acknowledge this lien/assignment by signing below and returning to the doctor's office. The undersigned agrees that a copy of this lien may be forwarded to third parties responsible for payment to the patient and that such third parties can act directly in protecting such lien/assignment. Such insurance benefits shall include any coverage's provided to the patient(s) for liability, disability, medical payments coverage, no-fault, health and accident, workers compensation and any other applicable benefits. Such insurers are directed and authorized to withhold and reimburse to my doctor such amount as necessary to satisfy the total sum owed by me for chiropractic services. The undersigned patient further acknowledges and agrees that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs.

This agreement shall be binding upon the patient's heirs, successors, personal representatives or assigns.

_____ _____

Dated Patient's Signature
(or Parent/Legal Guardian if Patient is Minor)

The undersigned, being attorney of record for the above patient (and/or insurance company representative), does hereby acknowledge receipt of this notice and hereby agrees to honor and comply with all the terms of the above agreement and agrees to protect adequately and/or otherwise withhold such sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney and/or insurer further acknowledge that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs. This agreement shall be binding upon any successor, agent, representative, employee or substituted and/or added attorney(s) of the patient with the same force and effect.

_____ _____

Dated Attorney/Insurance Representative Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Caledonia Chiropractic Clinic
5401 Douglas Ave, Suite A
Racine, WI 53402
262.681.8829

ASSIGNMENT AND DIRECTIVE TO PAY

_____

_____

Patient's Date of Birth: _____ SS#: __ __ __ - __ __ - __ __ __ __

I hereby authorize CALEDONIA CHIROPRACTIC CLINIC, to furnish you, my attorney(s), with a full report of case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved on or about:

Date of Accident_____

I hereby authorize and direct you, my attorney(s), to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor and to pay directly to him such sums as may be due and owing him for professional services rendered to me by reason of the aforesaid accident. This is intended to be a legally binding, irrevocable assignment of my rights and a directive to you or any other attorney who acts as my fiduciary agent in this matter. **I acknowledge and understand that using my debt to Dr. Schneider as a negotiating instrument against any liable third party constitutes a declaration of the validity of that debt and the Wis. Supreme Court has stated that failure to satisfy it upon receiving payment for that purpose could be an act of fraud on the part of myself and you, my fiduciary agent in this matter.**

If said settlement, judgment or verdict will not provide adequate funds to satisfy all of the debt that I accrue as a result of the above accident, I hereby direct you to inform Dr. Tim Schneider, D.C. of that fact immediately upon knowing it and provide him with a complete description of the settlement and any claims that exist against it so that he may make an informed decision of how or whether he might proceed to collect all that I owe to him.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered to me and that this agreement is made solely for his additional protection in consideration of pending payment. I further understand that such payment is not contingent upon any settlement, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____**Date:**_____

Address_____

City_____ State_____ Zip_____

Telephone: (____) __ __ __ - __ __ __ __

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NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize Caledonia Chiropractic Clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, progress, etc., of myself in regards to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as maybe due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor any change or addition of attorney(s) used by me to connection wit this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient Signature _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____ Attorney's Signature _____

Please date, sign and return one copy to doctor's office. Keep one copy for your records.

Doctor: _____