Dr. Gary Olson
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Personal Injury Questionnaire

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Name: _____ Sex: _____ Date Of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: ( ) _____Cell: ( ) _____ Marital Status: _____

Social Security #:_____ E-mail Address: _____

Referred to this office by: ☐Friend_____ ☐Dr._____ ☐Other_____

Insurance: _____ Address: _____ City: _____

State: _____ Zip: _____ Phone: ( ) _____ Claim#: _____

Claims Adjuster: _____ Phone: ( ) _____Policy#:_____

Describe the accident……

Date of accident: _____**Time of accident:** _____ ☐AM ☐PM

Where did collision occur? _____

What happened: _____

_____

What kind of vehicle were you in? _____

Vehicle size: ☐ Compact ☐Mid-size ☐Light ☐Full-size ☐ Mini ☐Subcompact ☐Semi

Other Vehicle: ☐ Compact ☐Mid-size ☐Light ☐Full-size ☐ Mini ☐Subcompact ☐Semi

Your position in the vehicle:

☐Driver ☐ Front middle passenger ☐Front right passenger ☐Back left passenger

☐Back middle passenger ☐Back right passenger ☐Pedestrian

Action of car:

☐ Crossing an intersection
☐ Stopped at an intersection
☐ Stopped for a pedestrian
☐ Stopped in traffic
☐ Traveling at posted speed limit
☐ Traveling faster than the posted speed limit
☐ Turning left
☐ Traveling slower than the posted speed limit
☐ Turning right

Amount of damage to *your* vehicle:

☐Complete ☐ Extensive ☐Minimal ☐Moderate

Amount of damage to *other* vehicle:

☐Complete ☐ Extensive ☐ Minimal ☐Moderate

Approximate speed at time of impact: Your vehicle: _____MPH Other vehicle: _____MPH

Driving Conditions:

Weather: ☐ Clear ☐ Cloudy ☐ Drizzling ☐ Foggy ☐ Rainy ☐ Snowing ☐ Stormy ☐ Sunny

Road: ☐ Damp ☐ Dry ☐ Iced Over ☐ Wet ☐ Snowed over ☐ Dry with icy patches

Visibility: ☐ Good ☐ Fair ☐ Poor

Body position at impact: (i.e. leaning forward/bracing) _____

Was vehicle pushed? *If yes which way?* ☐ Forward ☐ Backward ☐ Sideways

Direction body was thrown: _____ Direction head was thrown: _____

Head position at impact: _____ Position of head rest: _____

Were you wearing a seatbelt? ☐ Yes ☐ No

Did the vehicle go into a spin or roll as a result of impact? ☐ Yes ☐ No

Were brakes being applied? ☐ Yes ☐ No **Did airbags deploy?** ☐ Yes ☐ No

Was your ankle turned? ☐ Yes ☐ No **Did your head ride over headrest?** ☐ Yes ☐ No

Did you strike anything in vehicle at time of impact?

If yes, specify what part of your body struck what? (I.e. head chest chin shoulder left knee)

Steering Wheel _____ Dashboard _____ Windshield _____

Roof _____ Door _____ Window _____

Seat _____ Other _____

POST INJURY……

Immediately following the injury, how did you feel?

☐ Shaken ☐ Upset ☐ Nervous ☐ Confused ☐ Frightened ☐ Dazed ☐ Distressed
☐ Light headed ☐ Dizzy ☐ Weak ☐ Disoriented ☐ Nauseous ☐ Other _____

Where did pain occur? _____

Did you lose consciousness? ☐ Yes ☐ No ☐ Unsure **If yes, how long?** _____

What type of emergency treatment did you receive?

☐ Bandaging ☐ Bracing ☐ CPR ☐ A neck collar ☐ Splinting ☐ Other_____

Immediate destination after injury:_____

Who drove you there?_____**Where were cuts located?**_____

Were you admitted to the hospital? ☐ Yes ☐ No **If yes, How long?** _____

When did you go to the hospital? ☐ At time of accident ☐ Next day

How did you get to hospital? ☐ Ambulance ☐ Police car ☐ Private Transportation

Name of Hospital: _____ Attended by Dr._____

Were any of the following radiological tests performed? If yes, what part of the body?

X-ray: _____ MRI: _____ CAT Scan: _____

Treatment administered: _____

Recommendations: _____

Medications Prescribed: _____

Have you had multiple visits to one facility for this injury? ☐ Yes ☐ No **How many?** _____

Have you had multiple visits to several facilities for this injury? ☐ Yes ☐ No **How many?** _____

Circumstances: ☐ Aggravation or re-injury ☐ Lack of progress/Healing

☐ Continued pain ☐ New injury affecting this complaint

List any other doctors you have seen for this condition:

Dr. _____ Specialty: _____ Initial visit date: _____

Treatment Administered: _____

Dr. _____ Specialty: _____ Initial visit date: _____

Treatment Administered: _____

Dr. _____ Specialty: _____ Initial visit date: _____

Treatment Administered: _____

Please list all medications you are currently taking with condition:

Medication:	Condition:

Chief Complaints and Symptoms……

Neck pain—Select areas that the pain runs into from the neck

☐ None ☐ Head ☐ Upper back pain

☐ Left shoulder ☐ Left arm ☐ Left forearm ☐ Left wrist ☐ Left hand

☐ Right shoulder ☐ Right arm ☐ Right forearm ☐ Right wrist ☐ Right hand

Back pain—Select areas that pain runs into from back

☐ None	☐ Low Back	☐ Mid Back	☐ Upper Back	☐ Buttocks
☐ Left buttocks	☐ Left Hip	☐ Left thigh	☐ Left Knee	☐ Left foot
☐ Right Buttocks	☐ Right thigh	☐ Right Hip	☐ Right Knee	☐ Right foot

Other Symptoms:

☐ Headaches	☐ Pain in hands or Arms	☐ Chest pains
☐ Neck Pain	☐ Numbness in hands or arms	☐ Heart attack
☐ Sleeping Problems	☐ Pain in legs or feet	☐ High blood pressure
☐ Low Back Pain	☐ Tension	☐ Nervousness
☐ Irritability	☐ Lights bother eyes	☐ Depression
☐ Loss of Memory	☐ Pain between shoulders	☐ Dizziness
☐ Neck Stiff	☐ Sinus	☐ Shoulder pain
☐ Shortness of Breath	☐ Fever	☐ Joint swelling
☐ Loss of Balance	☐ Allergies	☐ Asthma
☐ Jaw clenching	☐ Nightmares	☐ Difficulty sleeping at night
☐ Excessive irritability	☐ A loss of concentration	☐ Fatigue
☐ Grinding of teeth at night	☐ Fear of driving in a car	☐ Anxiety
☐ Ringing in ears	☐ Blurry Vision	☐ Jaw pain

My pain is worse when I:

☐ Cough or sneeze	☐ Sit	☐ Bend	☐ Walk	☐ Lift	☐ Push
☐ Pull	☐ with sexual activity		☐ Sleep/wakes me up during the night		

Have you lost any time from work due to your injuries? ☐ Yes ☐ No

If yes, please give dates: _____

Type of employment: _____

Have you had any previous accidents? ☐ Yes ☐ No

Describe previous accident: _____

_____

Describe previous injuries: _____

_____

Is there any residual pain from the previous injury? ☐ Yes ☐ No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.)_____

Additional symptoms/complaints: _____

_____

Signature of patient or Legal Guardian: _____ **Date:** _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

18. Is patient still under your care for this condition? [ ] Yes [ ] No

19. Estimated duration of future treatment:

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer **(Authorization to Pay Benefits)** so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20.___ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

Print Name: _____ Signed: _____

Patient Patient

PATIENT: Your health provider may agree to have you assign your rights to No-Fault benefits from your insurer directly to your health provider **(Assignment of Benefits)**. If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21.___ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

Print Name: _____ Signed: _____

Patient Patient DATE

Print Name: Dr. Gary Olson Signed: _____

Provider of health care service (Assignee) Provider of health care service DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? [ ] Yes [ ] No

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? [ ] Yes [ ] No

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWLINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN Identification number	WCB Rating Code