Ratio Wellness
& Chiropractic Clinic
5201 Walnut Ave., Suite #2
Downers Grove, IL 60515

PERSONAL INJURY REPORT

Patient Name: _____ Date of Injury:_____
Time of Injury: _____AM/PM

TYPE OF INJURY: ☐ WORK INJURY ☐ AUTO ACCIDENT ☐ OTHER

Injured at: _____
City, State, Zip: _____

Have you been treated by another doctor for this accident? ☐ Yes ☐ No
If yes, please list doctor's name and address _____
_____
Type of treatment received_____
How long were you treated by this doctor? _____

Is your condition: ☐ improved ☐ unchanged ☐ worse ☐ constant
☐ comes & goes ☐ interferes with sleeping
Is your condition: ☐ worse in morning/mid-day ☐ worse in the evening
Does it hurt: ☐ during bowel movement ☐ during sex
What makes it feel better? _____ Worse? _____
Prior to this injury, have you ever had any physical complaints similar to what you have now?
☐ Yes? ☐ No?
If yes, please describe: _____
_____
_____
Have you ever been involved in an accident before? ☐ Yes ☐ No
If yes, please describe (include date, symptoms, etc.) _____
_____
_____
What medications are you taking? _____
Have you lost time from work as a result of this injury? ☐ Yes ☐ No
If yes, date last worked _____ Dates off work _____
Have you noticed any restrictions as a result of this injury? _____
_____

COMPLETE THE FOLLOWING IF THIS IS A WORK INJURY

Employer _____ Address _____

_____

Was this reported to employer? ☐ Yes ☐ No

Name of person reported to _____

COMPLETE THE FOLLOWING IF THIS IS AN AUTO ACCIDENT

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Wearing seat belts? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Number of passengers in your car _____ Your vehicle type _____

Speed: _____ mph

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No

In your own words, please describe the accident: _____

_____

_____

_____

_____

_____

_____

Where were you taken after the accident? _____

Other pertinent information/comments _____

_____

_____

_____ _____

Patient Signature Date

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(630)719-9700

WORKERS' COMPENSATION AUTHORIZATION

DATE_____ DATE OF ACCIDENT_____

EMPLOYER_____

SUPERVISOR_____

EMPLOYEE_____

INSURANCE CARRIER_____
ADDRESS_____
INSURANCE PHONE_____
ADJUSTER/AGENT_____

AUTHORIZED BY TELEPHONE_____ SPOKE WITH_____
DATE_____

SPECIAL INSTRUCTIONS_____
_____

The above patient has reported to our office for examination and chiropractic treatment due to injuries sustained while on the job. Please complete this authorization form, sign, and return to our office. We also request a copy of the completed EMPLOYEE'S INJURY REPORT for our files.

Thank you for your assistance.

_____ _____
Employer's Authorized Representative Signature Title

ratio wellness & chiropractic

DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____

_____

_____

DOCTOR:

Frederic Ratio, D.C.

RE: Patient's records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to 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, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Patient Signature:_____

The undersigned, being attorney of record of authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same protect adequately said above named doctor.

Dated: _____ Authorized Signature: _____

Notice: Please date, sign, and return one copy to doctor's office at once.
Keep one copy for your records
Reply envelop attached

5201 Walnut Ave., Suite #2 Downers Grove, Illinois 60515 Phone 630.719.9700 Fax 630.719.9703