Dr. Nick Wise at Center of Motion 400 Market St, Suite 105 Chapel Hill, NC 27516 p: (919) 966-8656 e: drnickwise@gmail.com

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

How and where did the accident happen? Describe in your own words:
_____
_____
_____

What was your position in the car?
□ Driver… If Driver**, were your hands on the steering wheel?** □ Left □ Right □ Both
□ Passenger… If passenger**,** were you sitting in □ Front □ Right Rear □ Left Rear
Did your vehicle strike another vehicle: □ Yes □ No **Was your vehicle struck by another vehicle** □ Yes □ No
Angles of impact… First Collision: □ Front □ Back □ Left □ Right **If Second Collision**: □ Front □ Back □ Left □ Right
Were you wearing a seat belt? □ Yes □ **No** **Did you brace for impact?** □ Yes □ No … □ I braced with my hands
□ I braced with my feet **Which way were you facing at the time of impact…** □ straight ahead □ Left □ Right

Did you strike anything in vehicle at time of impact? □ Yes □ No **If yes, specify what part of your body struck what**: ie… *head chest chin shoulder Right / Left Knee*
□ Steering Wheel _____ □ Dashboard _____

□ Windshield _____ □ Roof_____

□ Left Side Door _____ □ Right Side Door_____

□ Left Side Window. _____ □ Right Window _____

Other _____

Did the seat back bend / break? Yes No **Immediately following the accident, how did you feel?** dizzy/dazed disoriented unconscious nervous nauseous upset weak Other _____

Did you go to hospital Yes No **Were you admitted to the hospital?** □ Yes □ No **If yes how long?** _____
If you went to hospital, when? □ At time of accident □ Next day **How did you get to hospital**? □ Ambulance
□ Police Car □ Private Transportation **Name of Hospital**:_____
Attended by Dr. _____
… what treatment was given? □ none □ placed in a cervical collar □ x-rayed □ given stitches □ Bandaged □ given pain medication □ given instructions regarding concussions □ given instructions regarding sprains and strains □ Physical Therapy □ instructed to call a Orthopedic Surgeon □ instructed to call a private physician □ referred to this office for treatment □ Other _____

Have you seen any other doctor as a result of this accident? □Yes □ No Doctor's name : _____

If so, what treatment was given? _____

CHIEF COMPLAINTS & SYMPTOMS

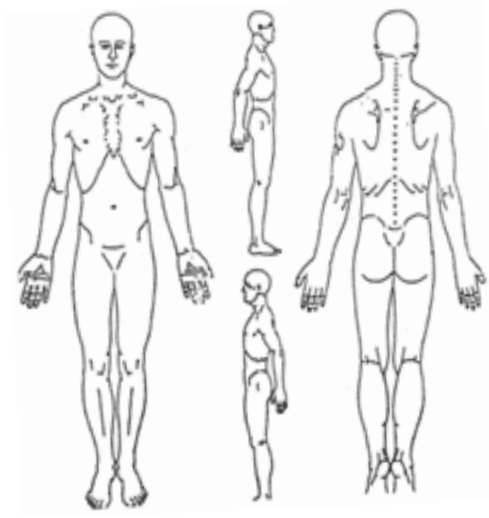
□ **Neck pain** (*check off the areas that the pain runs into from the neck* …) □ none □ left shoulder □ left arm
□ left forearm □ left hand □ right shoulder □ right arm □ right forearm □ right hand

□ **Headache** □ Migraine Headache □ Tension Headache □ Upper Back pain □ Chest or Rib Pain

□ **Ringing in Ears** □ Left □ Right □ Both
□ **Wrist Pain** □ Left □ Right □ Both
□ **Jaw Pain** □ Left □ Right □ Both

□ **Blurry Vision** □ Left □ Right □ Both
□ **Elbow Pain** □ Left □ Right □ Both

Mark all areas of symptoms



□ **Low Back Pain** (*select the areas of radiation, if any…*) □ none
□ both buttocks □ left buttock □ right buttock
□ left thigh □ left knee □ left foot □ right buttock
□ right thigh □ right knee □ right foot

Hip Pain □ Left □ Right □ Bilateral
Knee Pain □ Left □ Right □ Bilateral
Foot Pain □ Left □ Right □ Bilateral

Numbness/Tingling/Parasthesia:
□ Left Hand □ Left Upper Arm
□ Right Hand □ Right Upper Arm
□ Left Foot □ Left Leg □ Right Foot □ Right Leg

□ dizziness □ nervousness □ fatigue □ anxiety □ depression □ excessive irritability □ fear of driving in a car
□ jaw clenching □ a loss of concentration □ nightmares □ grinding of teeth at night □ difficulty sleeping

Additional Symptoms/ Complaints:

_____

_____

_____

_____

Initial _____

Have you lost any time from work due to your injuries? □ Yes □ No If yes please give dates: _____ to _____
Type of employment: _____ Have you had previous injuries or accidents? □ Yes □ No
Description of previous Accident(s):_____
Description of similar 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.) _____%

Anything else the doctor should know about? _____
_____

Thank you!

Dr. Nick Wise at Center of Motion
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DOCTOR'S LIEN ON PERSONAL INJURY RECOVERY

This agreement is entered into between Dr. Nicholas Wise (hereinafter, "Provider"), and _____ (hereinafter, "Patient"), in consideration of the obligations set forth herein and establishes certain obligations and responsibilities relating to Patient's accident of _____, 20___, (hereinafter, "claim") and resultant case with _____ (hereinafter, "Insurance Company.)

1. Patient hereby gives a lien to Provider against all proceeds derived from this claim (whether by settlement, judgment, or otherwise) to secure payment of all fees owed to Provider by Patient for health care services and supplies arising out of injuries sustained, as of the time such proceeds are paid. This lien shall have priority over any subsequent lien or assignment of Patient's interest. Patient hereby directs Patient's attorney and all responsible parties to pay such sums as are secured hereby directly to Provider, as soon as possible after any proceeds are received.
2. **Patient hereby expressly recognizes that even though this lien has been given, Patient still remains personally responsible for Provider's fees and that payment of such fees must be made by Patient regardless of whether any money is received through Patient's personal injury claim.**
3. Patient hereby authorizes Provider to furnish Attorney or Automobile Insurance Company, at reasonable intervals upon request, complete reports of Patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within a reasonable time, and at a reasonable cost.
4. Provider hereby agrees to await Patient's payment of Provider's fees until this claim is concluded, except to the extent that payment is available from insurance which provides health care benefits for Patient. Provider agrees to be available to Patient's Attorney, upon reasonable notice and for reasonable compensation for consultations, depositions and court appearances. In the event Provider is requested or subpoenaed to testify, Provider shall be entitled to reasonable compensation as an expert witness.
5. In the event of any dispute between the Provider and the Patient concerning Provider's fees, Attorney shall hold in trust until such dispute is resolved, or to deposit with the Court, a sufficient amount of Patient's proceeds to satisfy Provider's claimed fee.
6. Patient hereby agrees to notify Provider, immediately, should Patient retain new legal counsel. Patient agrees to direct new legal counsel to execute another copy of this Claim Agreement and Lien when one is furnished by Provider. Should new legal counsel fail or refuse to execute another copy of this lien agreement, within ten days after being provided a copy, then Patient's bill shall become immediately due and payable in full.
7. Should any party seek judicial enforcement of this agreement, the prevailing party shall be entitled to reasonable attorney's fees.
8. This Claim Agreement and Lien cannot be modified, changed, or revoked by any party without the express written consent of all parties.
9. A faxed or emailed signature on this lien shall be as effective as an original signature.
10. [If applicable] The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor named above.

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

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

[If applicable] The signed Attorney acknowledges receipt of a copy of this lien and agrees to be bound hereby.

Attorney's Signature: _____ Date: _____