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Motor Vehicle Crash Questionnaire

Full name: _____ Today's date:_____

History of Crash/Subjective Complaints

History of Occurrence

Date of crash: _____ Time: _____ ☐ a.m. ☐ p.m. Were you alone in the car? ☐ yes ☐ no
☐ Driver Passenger: ☐ front right ☐ front middle ☐ rear right ☐ rear middle ☐ rear left
Driver of car: _____ Who owns the car?_____ Year and model of car: _____
Where was the crash? City:_____ Street: _____Cross street: _____
Direction of travel: _____
Visibility at time of crash: ☐ Poor ☐ Fair ☐ Good
Road conditions at time of crash: ☐ Icy ☐ Rainy and wet ☐ Clear ☐ Dark

If other vehicles were involved, type of vehicle(s):
_____
Please tell us about the crash: Was it a rear impact, front impact? (note the car you were in as car "A")

_____
_____
_____
_____
_____
_____

Did the police come to the crash scene? ☐ Yes ☐ No
Did an ambulance come to the crash scene? ☐ Yes ☐ No
Were you transported by ambulance to the hospital? ☐ Yes ☐ No If yes, which hospital?_____
What was the approximate damage done to the car you were in? $_____ Was it driveable? ☐ yes ☐ no
How much damage was there to the other vehicle? _____ Was it driveable? ☐ yes ☐ no

Impact/Seat Belt/Headrest/Speed

Seat belt use: Were you wearing a ☐ Lap belt ☐ Shoulder belt ☐ Both ☐ No belt worn
Were you prewarned that the accident was about to happen? ☐ Yes ☐ No
Did you brace for the impact? ☐ Yes ☐ No
Does your car have headrests? ☐ Yes ☐ No

Impact/Seat Belt/Headrest/Speed (continued)

If your car does have headrests, what was the position of those headrests compared to your head before the accident? ☐ Top of headrest even with bottom of head ☐ Top of headrest even with top of head
☐ Top of headrest even with middle of neck

Was your car braking? ☐ Yes ☐ No Was your car moving at the time of accident? ☐ Yes ☐ No

If your car was moving, how fast would you estimate you were going?_MPH (estimate)

How fast was the other car traveling?_____MPH (estimate) ☐ Don't know

Head/Body Position

Head/body position at time of impact: ☐ Head turned left ☐ Head turned right ☐ Head looking back
☐ Head forward ☐ Body straight in sitting position
☐ Body rotated left ☐ Body rotated right

Position of right and left arms at time of impact (ie: on steering wheel)_____

Position of right and left feet at time of impact (ie: on brake)_____

Did the impact cause your seat back to slip backward or break? ☐ Yes ☐ No

Describe, in your own words, what happened to you upon impact:_____

_____

At the time of the crash, recall what parts of your head or body hit what parts on the inside of your car:

_____

As a result of the crash, were you: ☐ Rendered unconscious ☐ Dazed, circumstances vague
☐ Shaken up, but could function

If you did lose consciousness or strike your head in the crash please fill out the Rivermead questionnaire

Could you move all parts of your body? ☐ Yes ☐ No

If no, what body parts could you not move, and why?_____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

If no, why couldn't you get out of the car and walk unaided? _____

Did you get any bleeding cuts or bruises? ☐ Yes ☐ No

If yes, what bleeding cuts did you get from this crash? _____

If yes, what bruises did you get from this crash?_____

Please describe how you felt immediately after the crash (please be specific)_____

_____

Later that ☐ Day ☐ Night _____

The next days: _____

First Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, who did you first get treatment from? _____

Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you?_____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Second Doctor/Hospital/Clinic Seen

Second doctor/clinic seen: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you?_____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Third Doctor/Hospital/Clinic Seen

Third doctor/clinic seen: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you?_____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Activities of Daily Living

Do you notice any of your home activities that are different now than from before the accident? ☐ Yes ☐ No

If yes, list them as:

Those activities that you are now unable to do (be specific): _____

Those activities that are now painful to do (be specific): _____

Those activities that are now difficult to do (be specific):_____

Work Status History

Have you missed time from work? ☐ Yes ☐ No Unable to work since the crash? ☐ Yes ☐ No

If yes, full time off work: _____ If yes, part time off work: _____

Prior Similar Complaints

Did you have any physical complaints before the crash? ☐ Yes ☐ No

If yes, what physical symptoms did you have before the crash?_____

_____

Current Symptoms

List the present symptom(s) you are having:_____

_____

_____

_____

_____

Have you ever had a similar problem before? ☐ Yes ☐ No When? _____

_____

_____

Please explain in detail when and how your symptoms began: _____

_____

_____

What have you done to get relief?_____

_____

Current Pain Level

Please rate your pain severity on a scale of 0-10, with 0 being pain-free, and 10 the worst pain you have ever experienced.
How is your pain right now?

0	1	2	3	4	5	6	7	8	9	10
NONE	MILD Noticeable Pain, Minimal loss of motion.			MODERATE Moderate Pain that may cause Some degree of disability. Significant loss of motion.				SEVERE Severe Pain, Marked or total loss of motion.		

How high and low does your pain go? (circle 2 numbers)

0	1	2	3	4	5	6	7	8	9	10
NONE	MILD Noticeable Pain, Minimal loss of motion.			MODERATE Moderate Pain that may cause Some degree of disability. Significant loss of motion.				SEVERE Severe Pain, Marked or total loss of motion.		

What makes your condition worse?

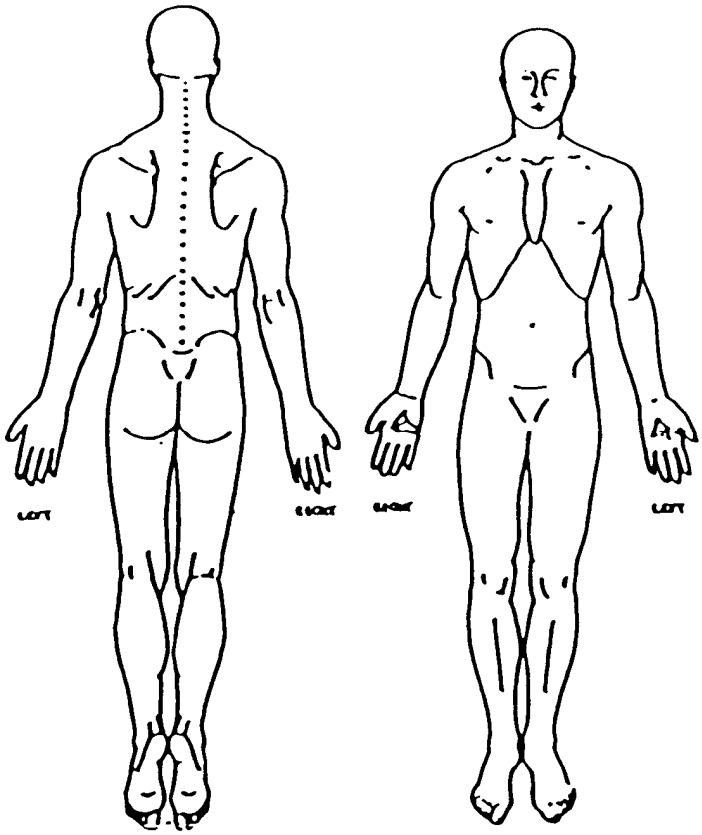
☐ Lifting	☐ Standing from seated position	☐ Nothing
☐ Walking	☐ Sitting	☐ Inactivity
☐ Exercise	☐ Standing	☐ Movement
☐ Home activities	☐ Work activities	☐ Other_____

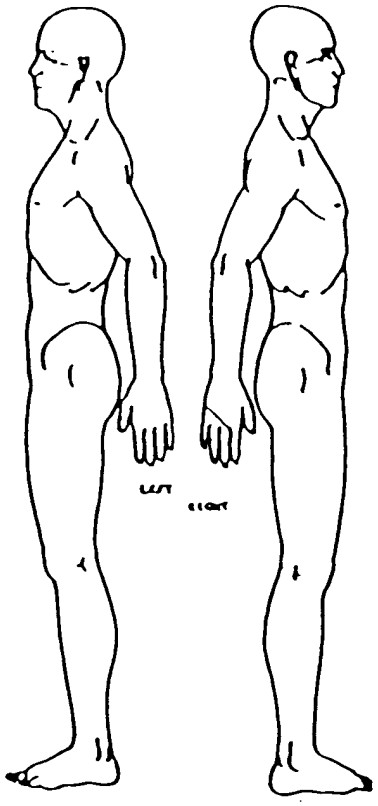
What makes your condition better?

☐ Standing	☐ Exercise	☐ Physical Therapy	
☐ Sitting	☐ Movement	☐ Pain Medication	
☐ Sleep	☐ Walking	☐ Anti-inflammatories	
☐ Lying down	☐ Inactivity	☐ Massage	
☐ Stretching	☐ Hot shower/bath	☐ Nothing	☐ Other____

Current Pain Level (continued)

Please mark your areas of pain on the figures below.
Shade and code area(s) of complaint: use codes: P = pain; N = numb; S = spasm
If these symptoms are spreading to other areas, please use arrows to show where and in what direction.





Check symptoms associated with your current problem:

☐ Headache	☐ Dizziness	☐ Sleeping problems	☐ Chest pain
☐ Neck pain/stiffness	☐ Fainting	☐ Numb feet/toes	☐ Nervousness
☐ Mid-back pain	☐ Ringing in ear	☐ Numb hands/fingers	☐ Eyes sensitive to light
☐ Low back pain	☐ Loss of balance	☐ Loss of concentration	☐ Unexplained weight change
☐ Loss of smell	☐ Pain behind eyes	☐ Loss of taste	☐ Weakness
☐ Depression	☐ Loss of memory	☐ Digestive disorders	

Do you have, or have you had, any of the following?

☐ Dizziness	☐ Asthma	☐ Headaches	☐ Digestive disorders
☐ Anemia	☐ Sinus trouble	☐ Numbness	☐ High blood pressure
☐ Heart trouble	☐ Heartburn	☐ Tuberculosis	☐ Loss of consciousness
☐ Diabetes	☐ Stroke	☐ Cancer	

Personal Information:

Date of birth: _____ Social security number: _____ Driver's license #: _____

Home address: _____City: _____ State:_____ Zip: _____

Home phone:_____Cell Phone_____Marital status:_____ Number of dependents:__

Your occupation: _____ Employer:_____ Work phone #: _____

Work address: _____ City: _____ State:_____ Zip: _____

Spouse, parent, or guardian's name:_____ Relationship:_____

Their address: _____ Their phone #: _____

Who referred you to our office? _____

Past History

Have you had any past significant injuries? (list with approximate year)_____

_____

_____

Have you been involved in any past motor vehicle accidents? ☐ Yes ☐ No When? _____

_____

If yes, were you injured? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

What significant illnesses have you had? _____

_____

Have you had any surgeries? (list with approximate year) _____

_____

What medications are you currently using?_____

_____

Mark any family illnesses: ☐ diabetes ☐ stroke ☐ cancer ☐ heart disease ☐ list all others _____

_____

Do you have a primary care physician? ☐ Yes ☐ No

If yes, who?

Have you received previous chiropractic care? ☐ Yes ☐ No If yes, by whom? _____

For what condition? _____

Is there anything else that you think the doctor should know?_____

_____

_____

_____

Billing Information

It is important that we have complete and correct billing information so that we can expedite your claim

Motor Vehicle Insurance (Vehicle you were riding in)

Date of crash?_____Were you: Driver/Passenger/Pedestrian (circle one)

Who owns the car?_____Your Auto Insurance_____

Policy #_____ Claim #_____

Driver's name_____Relationship to you_____

Driver's Insurance carrier_____ Policy #_____

Phone_____Adjustor_____

Insurance claims address_____City_____

State_____Zip_____

Attorney Name (if applicable)_____Phone #_____

Other car's Driver's Insurance Information

Other Driver's name:_____Phone:_____

Insurance Company name_____Policy#_____

Claims Address:_____City_____State_____Zip_____

PRIMARY HEALTH INSURANCE

Co-Pay$_____

Insured Name_____Date of birth_____SSN/ID#_____

Insurance Carrier_____Insurance phone_____

Group#_____Employer_____

Insurance coverage for chiropractic? ☐ Yes ☐ No

SECONDARY HEALTH INSURANCE

Insured's Name_____Date of Birth_____SSN/ID#_____

Insurance Carrier_____Relationship to patient_____

Insurance phone_____Employer_____Group#_____

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE AND AGREE TO ABIDE BY SAME.

Patient signature:_____ Date:_____

Guardian signature: _____ Date:

_____

ASSIGNMENT AUTHORIZATION AND LIEN STATEMENT

TO WHOM IT MAY CONCERN:

I hereby authorize and direct _____, my insurance company, and/or my attorney to pay directly to_____, my doctor, all such **reasonable and necessary** sums as may be due and owing to this office for services rendered by reason of accident or illness which occurred on _____ and to withhold such sums from any disability benefits, including but not limited to health and accident benefits or any other insurance, P.I.P. benefits, workers compensation benefits or any other insurance benefits obligated to reimburse the undersigned or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignee.

The parties further agree that, in the event my insurance company is obligated to make such payment, this agreement is to act as an assignment of the undersigned's rights and benefits to the extent of the cost of the services provided by this office. Therefore, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name and further I authorize this office and assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I hereby further give a full lien to said office against any and all insurance benefits named herein which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by said health care provider. A photocopy of this assignment shall be considered as effective and valid as the original.

It is further agreed that the undersigned patient shall remain personally responsible for the total amount due this office and assignee for its services. The undersigned further understands and agrees that this assignment, lien and authorization does not constitute any consideration for the office to await payment and that they may demand payment in full immediately upon tendering service at their option. It is understood that as necessary the necessary health care provider may submit, prepare or complete medical reports, consultations, depositions and court appearances on my behalf which are not considered part of my account unless such is approved in advance.

I authorize the health care provider to release any information pertinent to my case to any insurance company, adjustor, attorney or legal service bureau to facilitate collection under this assignment, lien and authorization.

DATE: _____ _____

Patient or Guardian

My insurance Company _____

See: Marvin v. State Farm, 894 SW2d 712 (1995).

DOCTOR'S LIEN

I do hereby authorized Dr._____ to furnish you, my attorney, with a full report concerning examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct that you pay directly to my doctor such sums as may be due and owing for chiropractic services rendered as a result of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give an irrevocable lien on my case to said doctor against any and all proceeds of my 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 understand that I am directly and fully responsible to said doctor for all bills submitted by my doctor for services rendered and that this agreement is made solely for the doctor's additional protection and inconsideration of waiting for payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

If the doctor's bill is more than 30 days past due, then I understand and agree to pay interest at the rate of 18 percent per annum on the unpaid balance until paid.

Please acknowledge this letter by signing below and returning this letter 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 will require me to make payments of a current basis.

Patient Name (Print)

Patient Signature Date

For Attorney Use

The undersigned, being my attorney of record for the above patient, does hereby agree to observe all terms above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

Attorney Name (Print)

Attorney Signature Date