MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

   _____

   _____

   _____

2. Phone Number: _____

3. Please describe the collision in your own words:

   _____

   _____

   _____

4. Where did the collision occur? City/Town: _____ State: _____
5. Date of collision: _____ Time: _____ AM PM
6. Were you the: ☐ driver ☐ passenger ☐ pedestrian
7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
8. What type of vehicle were you in? _____
9. What type was the other vehicle? _____
10. Did your vehicle strike the other vehicle? ☐ yes ☐ no
11. Was your car struck by the other vehicle? ☐ yes ☐ no
12. What direction was your vehicle going? _____
13. What direction was the other vehicle going? _____
14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side
15. What was the approximate speed at the time of the impact?

    Your vehicle _____ mph Other vehicle _____ mph
16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐moving ☐stopped
18. Were your brakes being applied? ☐ yes ☐ no
19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
20. Were you shoved: ☐ forward ☐ whipped backward
21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

22. If yes, what was the position ☐ low ☐ midposition ☐ high
23. Did your head ride over the headrest? ☐ yes ☐no
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard ☐ windshield ☐ side door ☐ side window ☐ other _____
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee ☐ R L shoulder ☐ R L hand ☐ other _____
28. Were you holding on to the steering wheel? ☐ yes ☐ no
29. Did you brace your arms against the dash? ☐ yes ☐ no
30. Did you brace your legs against the floorboard? ☐ yes ☐ no
31. Was your ankle turned? ☐ yes ☐ no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
35. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
36. At the point of impact, where did you experience pain? Be specific:

_____

_____

37. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? ☐ yes ☐ no
40. Did the belt have a shoulder harness? ☐ yes ☐ no
41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no
42. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right ☐ looking to the left ☐ looking down ☐looking up
43. Did the seat break as a result of the impact? ☐ yes ☐ no
44. Were you braced for the impact? ☐ yes ☐ no
45. Were you surprised by the impact? ☐ yes ☐ no
46. Did you go to the hospital? ☐ yes ☐ no
47. If yes, when? ☐ right after the accident ☐ next day ☐ other _____

48. If yes, how did you get there? ☐ ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace ☐ back brace ☐ other _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? ☐ yes ☐ no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

_____

52. Have you had any similar problems before? ☐ yes ☐ no

53. If yes, explain: _____

54. Are you diabetic? ☐ yes ☐ no

55. Do you have high blood pressure? ☐ yes ☐ no

56. Do you have low blood pressure? ☐ yes ☐ no

57. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? ☐ yes ☐ no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? ☐ yes ☐ no

Name of adjuster handling claim _____

Will company accept assignment of benefits? ☐ yes ☐ no

If not, will they make checks payable to patient and our office? ☐ yes ☐ no

Limits: How much? $_____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? ☐ yes ☐ no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

_____

_____

_____

_____

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? ☐ yes ☐ no

In the event of settlement, will they protect any unpaid balance? ☐ yes ☐ no

Do they have PIP? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Do they have insurance? ☐ yes ☐ no Do we file? ☐ yes ☐ no

Can we file liability? ☐ yes ☐ no

First Chiropractic

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MEDICAL REPORTS AND DOCTOR'S LIEN AUTHORIZATION

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself, in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing said doctor from all monies received which are intended, in whole or in part, as payment, reimbursement or compensation for medical services rendered. These funds shall include, but are not limited to, all group or private medical insurance payments, all automobile medical payments (med-pay) funds, all workers compensation medical expense payments and all sums received through any settlement, judgment, verdict or arbitrator's award. I, hereby, further give an irrevocable lien in favor of said doctor on my claim for personal injuries and on all funds paid, from any source, as payment, reimbursement or compensation for medical services rendered.

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

Please support this agreement by signing below and returning it 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 pay on my account to keep it on a current basis.

Dated_____ Patient's Signature_____

The undersigned (being attorney of record for the above patient), hereby agrees to uphold all terms stated above. It is further agreed that any monies received (which are intended as a partial or full payment/reimbursement to above patient) will be withheld in sufficient sums to fully secure the interest of Dr. _____, paid to said physicians upon receipt of those monies (with no disbursements to be delayed by an anticipated settlement, arbitration, judgment or verdict). Said monies are defined as (but not exclusively limited to): all group or private medical insurance payments, all automobile insurance medical payments (med-pay) funds, all workers compensation medical expense payments, all sums through any settlement, judgment, verdict or arbitrator's award.

Dated_____ Attorney's Signature_____

(Attorney: Please date, sign and return a copy to the doctor's office. A photocopy of this form shall be as valid as the original)