VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last	First	Middle	DATE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	BUSINESS PHONE

SOCIAL SECURITY #	BIRTH DATE	HEIGHT	WEIGHT	SEX

MARITAL STATUS	NO. OF CHILDREN	HOW WERE YOU REFERRED TO OUR OFFICE?

EMPLOYER	OCCUPATION

BUSINESS ADDRESS	E-MAIL ADDRESS

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:

DATE AND TIME OF ACCIDENT: ☐ A.M. ☐ P.M.	WERE POLICE NOTIFIED? ☐ Yes ☐ No	WERE YOU USING A SEATBELT? ☐ Yes ☐ No	YOU WERE: ☐ Driver ☐ Front Seat ☐ Passenger ☐ Back Seat

YOUR VEHICLE WAS HEADING: ☐ North ☐ South ☐ East ☐ West On: ☐ Highway ☐ Street

THE OTHER VEHICLE WAS HEADING: ☐ North ☐ South ☐ East ☐ West On: ☐ Highway ☐ Street

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?	DOCTOR'S NAME:	HOW OFTEN DID YOU SEE THIS DOCTOR?

WERE YOU UNCONSCIOUS? IF YES, HOW LONG? ☐ No ☐ Yes ➡	WHAT TREATMENT AND DIAGNOSIS WAS GIVEN?

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS & PHONE:
☐ No ☐ Yes ➡

PLEASE DESCRIBE YOUR INJURIES AND SYMPTOMS RESULTING FROM THIS ACCIDENT:

SINCE THIS INJURY, ARE YOUR SYMPTOMS:

☐ Improving ☐ The Same ☐ Getting Worse

LIST TWO MAJOR COMPLAINTS, AND CIRCLE THE INTENSITY OF PAIN.

	LOW			MOD			INTENSE			EMERGENCY
COMPLAINT # 1: ______________	1	2	3	4	5	6	7	8	9	10
COMPLAINT # 2: ______________	1	2	3	4	5	6	7	8	9	10

DID YOU OR ARE YOU STILL TAKING ANY MEDICATIONS FOR THIS INJURY?
☐ No ☐ Yes ➡

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)?
☐ No ☐ Yes ➡

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?
☐ No ☐ Yes ➡

DID YOU RETURN TO WORK? IF NO, HOW LONG WERE YOU OFF?
☐ No ☐ Yes

BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE? ☐ No ☐ Yes

Mark areas of pain resulting from this accident on figures below:

Right Left

Left Right

Patient Condition

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?____

Is it constant or does it come and go?____

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Routine

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatments have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other:____________________

Name and address of other doctor(s) who have treated you for your condition____________________

Date of Last: Physical Exam:__________ Spinal X-Ray:__________ Blood Test:__________
Spinal Exam:__________ Chest X-Ray:__________ Urine Test:__________
Dental X-Ray:__________ MRI,CT-Scan,Bone Scan:__________ Mammogram:__________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problem	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumor, Growth	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vaginal Infection	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	Other:__________		
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No						
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No						
			Measles	☐ Yes	☐ No						
			High Blood Pressure	☐ Yes	☐ No						

Exercise	Work Activity	Habits		Females
☐ None	☐ Sitting	☐ Smoking	Packs/Day __________	Are you Pregnant? ☐ Yes ☐ No
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week __________	
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day __________	Due Date:__________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason __________	

Injuries/Surgeries	Description	Date
Falls	__________	__________
Head Injuries	__________	__________
Broken Bones	__________	__________
Dislocations	__________	__________
Surgeries	__________	__________

Medications	Allergies	Vitamins/Herbs/Minerals
__________	__________	__________
__________	__________	__________

General Information

The amount of paperwork involved in Personal Injury is rather extensive. However, once completed, billing for your account usually runs smoothly Thank you for your cooperation. If you have any questions, please ask our staff for assistance.

MASSACHUSETTS LAW

Medical claims for the treatment you receive is paid by the Personal Injury Protection (PIP) portion of the policy of the VEHICLE YOU WERE RIDING IN. We request a copy of of the COVERAGE SELECTION PAGE and a copy of the ACCIDENT REPORT for our file to help expedite the processing of your claims.

Your name:_____________________________ Date of Accident:____________________________________

Town/City/State where the accident occurred:____

Personal Injury Insurance Information

Name of insured person who vehicle you were riding in: ____ Relationship:___________________

Their address: ____ City:_____________________ State:_____ Zip:________________

Name of the above insured's Automobile Ins carrier:____ Phone #:_________________

Address:____ City:_____________________ State:_____ Zip:________________

Have you reported your injury to this insurance company?________________ When was it reported?_________________________

Personal Injury Claim #?___________________________________ What is the adjuster's name?_____________________________

Have you received an application for Personal Injury Benefits from the ins. company?_______________ Please complete and mail ASAP.

Please provide copy of the coverage selection page.

IMPORTANT- Amount of deductible chosen under "Personal Injury Protection" portion of Automobile policy: $_____________

Name of your health insurance company: ____

Address:____ City:_____________________ State:_____ Zip:________________

Phone#:_______________________ Name of insured:______________________________

Insured's ID #:____________________________ Insured's Birthday:____________________ Relationship to insured:________________

Bodily Injury Carrier Information

If the driver of your vehicle was not at fault in the accident, the other party's insurance carrier is called the Bodily Injury Carrier in this situation. This carrier may be held responsible to pay your balance due if your own insurance denies paying the full benefits. Please provide this information so that we may look to them for your unpaid balance (if that is necessary at the end of your treatment) before we look to you.

Name of the person driving the other vehicle involved:____

Name of their Auto Insurance Carrier:____

Address:____ City:_____________________ State:_____ Zip:________________

Phone #:_______________________ Claim #:______________________________________

Do you have an attorney? _____________ Attorney's Name:____

Address:____ City:_____________________ State:_____ Zip:________________

Phone #:_______________________ Fax #:______________________________________

Assignment and Release

Our office is willing to accept your insurance assignment as soon as your coverage is verified. It must be understood that your insurance contract is between you and your insurance carrier. Our office does not guarantee that your insurance co. will pay your bill. You are required to sign a "Lein" on your first visit. HOWEVER IF, FOR ANY REASON YOU CLAIM IS DENIED BY YOUR INSURANCE CARRIER YOU ARE ULTIMATELY AND FULLY RESPONSIBLE FOR YOUR BILL.

PLEASE PHONE AHEAD IF YOU ARE UNABLE TO MAKE A SCHEDULED APPOINTMENT. If you are treating for a Motor Vehicle accident and continually fail to make scheduled appointments, you will be discharged. If you have been out of work it will be assumed that you are no longer disabled and are fully able to return to work.

Patient's Signature:____ Date:__________________________

Doctor's Signature:____ Date:__________________________