AUTO ACCIDENT QUESTIONNAIRE

THE WELL CHIROPRACTIC

Please answer all questions completely.

DEAR PATIENT: This information is considered confidential. In order to get the most coverage for your care, please be as neat and accurate as possible. Thank you.

NAME: _____ DATE:_____ PATIENT #:_____

PATIENT'S AUTO INSURANCE CO.:_____
POLICY #: _____ CLAIM #: _____
NAME OF YOUR INSURANCE ADJUSTER:_____
PHONE #: _____ FAX #: _____

MEDICAL PAY VERIFICATION

Your car insurance company will only release this information to you, the policy holder.
Please call your car insurance provider to obtain this information.
Using your medical pay will not raise your car insurance rates

Do you have auto medical pay/coverage? YES NO
If so, how much? $1,000 $2,000 $5,000 $10,000
Is your auto medical pay primary or secondary?_____
Name of primary insurance:_____
Do you have uninsured motorist's coverage on your auto insurance policy? YES NO
If so, what is the limit?_____

NAME OF DRIVER OF OTHER VEHICLE : _____ PHONE #: _____
OTHER DRIVER INSURANCE CO.:_____ PHONE #: _____
INSURANCE ADJUSTER: _____
POLICY #: _____ CLAIM #: _____

IF YOU WERE A PASSENGER PLEASE COMPLETE THE FOLLOWING:

Name of driver of vehicle:_____
Driver's insurance company: _____ Policy #: _____ Phone #: _____
Insurance adjuster: _____ Claim #: _____

HAVE YOU RETAINED AN ATTORNEY? ( ) YES ( ) NO
ATTORNEY/OFFICE NAME: _____ PHONE #: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT _____ CITY & STATE _____

You were heading: North (___) South (___) East (___) West (___)
On (street or highway) _____
Other vehicle was heading: North (___) South (___) East (___) West (___)
On (street or highway) _____
Road conditions at the time of accident: Wet (___) Dry (___) Icy (___) Other (___)

Were there any witnesses? Yes (___) No (____)
Did the police come to the accident scene? Yes (___) No (___)
Were you taken to the hospital? Yes (___) No (___)
If yes, what hospital? _____ How did you get to hospital? _____
What parts of your body were x-rayed at the hospital? _____
What treatment was given? _____
What was the diagnosis? _____
Was another doctor consulted after your accident? Yes (___) No (___) Doctor's name:_____
What treatment was given? _____
What was diagnosis? _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU, THE PATIENT AND THE VEHICLE YOU WERE IN:

How much damage to the vehicle you were in $ _____
Where were you seated in the vehicle?_____
Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?_____
Did you lose consciousness (black out) upon impact? Yes (___) No (___)
If you did lose consciousness, estimate for how long: _____
Where was the headrest at the time of the accident: ▢ Bottom of neck ▢ Bottom of head ▢ Middle of head
Were you: ▢ Driver ▢ Passenger ▢ Back Seat Driver Side ▢ Back Seat Passenger Side
You were struck from: ▢ Behind ▢ Front ▢ Driver side ▢ Passenger Side
Number of people in your car _____
Were you wearing a seatbelt? Yes (___) No (___)
If "yes" was it a lap seatbelt or a shoulder-lap seatbelt? _____
List the year, make, and model of the vehicle you were in: Year_____ Make _____ Model _____
Was your car stopped at the time of impact? Yes (___) No (___)
If "yes" was the driver's foot also on the brake? Yes (___) No (___)
If "no" please estimate the speed of the vehicle you were in _____ m.p.h.

Please describe how you felt:
During the accident: _____
Immediately after the accident: _____
Later that day: _____
The next day: _____
Since the accident, your symptoms are: ▢ Improving ▢ Getting Worse ▢ Same
Have you noticed any activity restrictions as a result of this accident? Yes (_____) No (_____)
If yes, please explain _____

QUESTIONS PERTAINING TO THE PATIENT AND THE VEHICLE:

If the vehicle was moving at the time of impact, was it:
Slowing down? Yes (___) No (___)
Gaining speed? Yes (___) No (___)
Traveling at a steady rate of speed? Yes (___) No (___)

Please describe in detail, to the best of your knowledge, what happened during this accident:

_____
_____
_____
_____
_____

What bleeding cuts did you get during this accident? _____
_____
What bruises did you get during this accident? _____
On what part of the auto did the following body parts hit:
Head hit_____
Chest hit_____
Right/left shoulder hit _____
Right/left arm hit _____
Right/left hip hit_____
Right/left leg hit _____
Right/left knee hit _____
Other _____

What of the following car parts broke during the accident:
Windshield (___) Front seat back (___) Right/left side window (___) Steering wheel (___)
Other: _____
Was the trunk of your body pointed straight forward at the time of collision? Yes (___) No (___)
If "no", which direction was it turned and by how much? _____
Do you have any previous illnesses which relate to this case ( ) Yes ( ) No
If yes, please describe: _____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete the following:
Last day worked: _____
Type of employment: _____
Present Salary: _____
Are you being compensated for time lost from work? ( ) Yes ( ) No
If yes, please state type of compensation you are receiving: _____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

What is the year, make, and model of the other vehicle?
Year _____ Make _____ Model _____
Was the other vehicle moving at the time of the collision? Yes (___) No (___)
If "yes", what was its approximate speed? _____ m.p.h.
If the other vehicle was moving at the time of collision, was it:
Slowing down? Yes (___) No (___)
Gaining speed? Yes (___) No (___)
Traveling at a steady rate of speed? Yes (___) No (___)