



AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____ Today's Date: _____

Patient's Address: _____

Patient's DOB: _____ SSN: _____ Date of Accident: _____

Phone Number: _____ Email Address: _____

Your Automobile Insurance Company:

Name of Company _____ Phone _____

Address _____

Claim # _____ Policy# _____

Third Party Insurance Company

Name of Company _____ Phone _____

Address _____

Claim # _____ Policy# _____

Adjusters Name _____ Direct Contact Number _____

Advising Attorney Information:

Name of Attorney _____ Phone _____

Address _____

Assignment of Benefits by a Patient to a Physician:

I hereby assign to my physician all benefits for such services to which I am entitled under my Personal Injury Protection and/or Medical Payments coverage, and request my insurance company to pay any such benefits directly to my physician upon submission of any claim.

Signed _____ Date _____

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

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver
 Passenger/Location Left Middle Right
 Other _____ Front Passenger Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx ____MPH
 Moving Slowly

Why Vehicle was slowed or stopped:

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection

Collision Type:

- Driver Side Impact Head On Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Bus Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- Totally unaware that the accident was impending
 Aware that the accident was impending
 Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- Seat belt
 Shoulder harness
 No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by impact

Was the air bag deployed?

- Car not equipped with air bag
- Air bag deployed
- Air bag not deployed

Position of YOUR head at time of impact?

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Position of Your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

What position was YOUR headrest in?

- High position
- Middle position
- Low position

Was your head thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left

Was your body thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left
- Across the vehicle
- Outside the vehicle Under the vehicle

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Torso

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:**Did you lose consciousness?**

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

At the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Next day discomfort...?

- increased decreased same

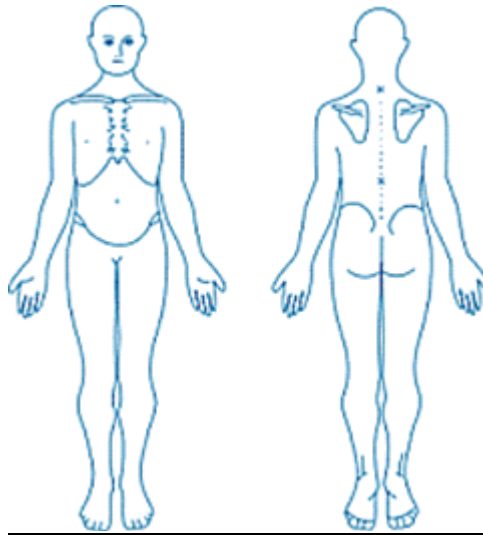
Did your major complaints exist before the accident?

- Yes No

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | | | | | | |
| <input type="checkbox"/> Pelvis | | | | | | |

Please mark your areas of pain on the figure below.



Chalmers Wellness Health Insurance Affidavit

In order for this office to process your claim efficiently, it is necessary to obtain the following information regarding other health benefits available to you.

Any medical expenses in excess of \$2,500 will not be paid under your Auto policy if those expenses will be compensated, paid, or indemnified by an outside insurance carrier. Bills submitted to your Auto insurance carrier over the \$2,500 limit must be accompanied by an explanation of benefits from your health carrier or a copy of this Affidavit.

I hereby certify that I have the following health insurance benefits available to me:

Health Insurance Co: _____

Policy Number: _____

I hereby certify this I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Signature

Date

Patient: _____

DOB: _____

MVA Date: _____

Patient: _____

Carrier 1: _____

Carrier 2: _____

Attorney: _____

RE: PATIENT RECORDS, IME REQUEST, PIP Application and DOCTOR'S LIEN

I do hereby authorize Crucible Physical Medicine to furnish my Attorney/Insurance carrier, with a full report of my case history, examination, diagnosis, treatment, and prognosis in regard to my accident/illness which occurred/began on _____.

I also authorize and request my Attorney/Insurance Company to send any IME report, PIP Application or request for me to attend an IME to Crucible Physical Medicine.

I hereby give a lien to said Doctor on any settlement, claim judgment, or verdict as a result of said accident/illness, and authorize and direct you, my Attorney/Insurance carrier, to pay directly to said Doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said Doctor adequately.

I understand that I am directly and fully responsible to said Doctors or Nurse Practitioner for all bills submitted by him for service rendered me and that this agreement is made solely for said Doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Signature: _____

The undersigned, being Attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named Doctor.

Dated: _____ Authorized signature: _____

INFORMED CONSENT

When a patient seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals. The practice of chiropractic in this office consists of analysis and adjustment of the spine for the purpose of locating and correcting vertebral subluxations. (Spinal misalignments causing nerve interference). We also strive to educate and encourage our patients/practice members to become aware of and responsible to their wellbeing.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of “treating” or “curing” diseases or conditions.

Physicians, chiropractors, osteopaths and physiotherapists using manual manipulation are required to advise their patients that there have been rare incidents of injury to the vertebral artery during the course of treatment. There have caused strokes or stroke-like occurrences which are usually of a temporary nature. The chances of this happening are approximately 1 in 3 million treatments. There have also been rare incidents of rib bruising or swelling of aggravation of symptoms. Appropriate tests will be performed on you to minimize your risks.

It is important that you understand that chiropractic care involves a “hands on” approach. During the delivery of a chiropractic adjustment or diagnostic procedure, there may be physical contact made in possibly sensitive areas. By signing below you are acknowledging that you have been informed of and consent to the type of care you will receive and that you have been made aware of any risks inherent in that care. You also acknowledge that you have been made aware of other treatment options. If a change in approach, additional testing, and referrals to other providers or a need to apply care requiring a different touch is required it will be discussed with you prior to it being administered. If at any time you are in any way uncomfortable with any aspect of the care that you are receiving, please do not hesitate to let us know.

Our practice is based on the simple truth that if we satisfy and delight our patients, they will get well faster and be more likely to tell others about their chiropractic experience. Since chiropractic results vary, we can't guarantee results, but we can promise your satisfaction. Within 3 days of beginning care, if you are not completely happy with your decision to begin chiropractic care in this office, we will happily refund the money you've paid us.

I/We understand and consent to care at Crucible Physical Medicine for myself/my family, as outlined in this “Informed Consent”.

Name (print): _____

Signed: _____

Date: _____

Nurse Practitioner Consent

Crucible Physical Medicine would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners to assist us in a team approach to deliver our high quality of medical care.

A Nurse Practitioner (NP) is a mid-level practitioner who has received advanced education and training in the provision of health care. They can however, diagnose, treat, and monitor routine and complex pain disorders. If you are seen by a Nurse Practitioner, your doctor will review your care with the NP as part of the care plan.

I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a NP.

I hereby consent to the services of a Nurse Practitioner for my healthcare needs.

Name (print): _____

Signature: _____

Date: _____