Automobile Accident History

Date: _____
Patient # _____

Last _____ **First** _____ **Middle Initial** _____ **Birth Date** _____ **Age** _____

Address _____ **City** _____ **ST**_____ **Zip** _____

Phone (H) _____ **(W)** _____ **(C)** _____

Email _____

Who may we thank for referring you to our office? _____ ☐Friend/Coworker ☐Advertisement ☐Google ☐Yelp

Who is your primary care physician? _____ **Address:** _____

Phone: _____ **Date of last physical/exam?** _____ **With Whom?** _____

Date of Accident: _____ **Time of Accident:** _____ **am / pm** ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

Was the accident on the job? ☐yes ☐no **Where you in a company vehicle?** ☐yes ☐no **Where were you seated in the vehicle?**

☐Driver ☐Passenger ☐Rear-seat ☐Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐yes ☐no **Did you experience a flash of light or explosion in your head?** ☐yes ☐no

Did the police come to the accident scene? ☐yes ☐no **Is there a police report**☐yes ☐no

Did you go to the hospital? ☐yes ☐no **When?** ☐Immediately ☐___hours later ☐___days later **Which hospital?** _____

How did you get to the hospital? _____ **How long did you stay in the hospital?** _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____

What areas were x-rayed? _____**What was their diagnosis?** _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐yes ☐no **If yes, please complete information below.**

Dr. _____ **Specialty?**_____ **Date first seen:**_____

Type of treatment:_____ **Treatment frequency:**_____ **How long did you treat?**_____

Dr. _____ **Specialty?**_____ **Date first seen:**_____

Type of treatment:_____ **Treatment frequency:**_____ **How long did you treat?**_____

Were you wearing a seatbelt? ☐yes ☐no **If yes, did you receive any injury or bruise from the seat belt?** ☐yes ☐no

Did your head hit the head rest during the accident? ☐yes ☐no **If adjustable, was the position of the head rest altered?** ☐yes ☐no

Was the seat adjustment altered by the accident? ☐yes ☐no **Was the seat broken by the accident?** ☐yes ☐no

Did the air-bag deploy? ☐yes ☐no **If yes, did it strike you?** ☐yes ☐no **If yes, where?** _____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left **Body?** ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐yes ☐no **If so, were they still on after the accident?** ☐yes ☐no

YOUR CAR

List the year, make and model of the car you were in: YEAR: _____ MAKE: _____ MODEL: _____

Was your car stopped at the time of impact? ☐yes ☐no I If no, estimate the speed of the vehicle you were in: _____mph

I f your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: _____ MAKE: _____ MODEL: _____

Was the other car moving at the time of impact? ☐yes ☐no If yes, what was the approximate speed of the vehicle : _____mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim #:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim#:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Have you retained an attorney? ☐yes ☐no **Name:** _____ **Phone #:**_____

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

Do you still have any of those symptoms? ☐yes ☐no **If yes, which ones?** _____

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

Body Part:_____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease?_____

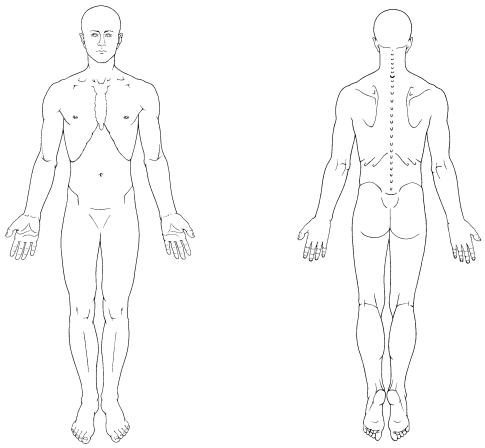
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



Do you smoke? ☐yes ☐no If yes, how many packs per week?_____**Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing **How long?** _____ ☐Lifting **How much?** _____ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐yes ☐no **If yes, how many days?** _____ **Dates:** _____

Are your work activities restricted as a result of this accident? ☐yes ☐no **If yes, please explain.**_____

Do any of your work activities aggravate your present main complaints? ☐yes ☐no **If yes, please explain.** _____

_____

Please list any medications or vitamins you are currently taking (including dosage).

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

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AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Discover Chiropractic & Rehabilitation* and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print)_____

Name of Parent / Guardian (please print) _____

Parent / Guardian signature: _____ **Date:** _____

Election not to file health insurance - Please sign here if you are electing NOT to file claims to your health insurance

I do not wish to file claims for dates of service rendered through my health insurance . I understand that claims will be submitted to MedPay under my own automobile insurance and/or billed to the responsible party. I also understand that I am ultimately financially responsible for any outstanding balance.

Patient's SIgnature: _____Date: _____

Insurance Payments:

We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payment of services regardless of the amount your insurance pays. In other words, if for some reason your insurance company withholds payment, you are responsible for your balance due.
***We base your financial contribution on the benefits quoted to us from your insurance company. There are times when we are misquoted benefits. It is your responsibility to understand your own coverage and any portions for which you may be responsible.

Patient's SIgnature: _____Date: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Gard Wellness Center any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Gard Wellness Center the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Gard Wellness Center the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____Date:_____

Printed name: _____

Witness:_____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature **Date**