WHOLE CHIROPRACTIC HEALTHCARE

Auto Accident Questionnaire

Please complete all of the following questions regarding your accident. These details are very important, and the doctor will use them with his examination and final care plan.

Full name _____ Today's date _____
Date of accident _____ Type of vehicle(s) involved _____
Location of accident (intersection/street) _____ City _____ State ____
Time of accident _____Other details _____
_____

Explain the accident in your own words _____
_____
_____
_____

1. **What area(s) <u>ARE OR WERE</u> painful since the accident?** (Circle ALL areas.)

Neck	Upper back	Mid-back	Lower back
Shoulder (right left)	Elbow (right left)	Wrist (right left)	Hand (right left)
Hip (right left)	Knee (right left)	Ankle (right left)	Foot (right left)
Headaches	Other _____		

2. **New onset of headaches** Yes ❑ No ❑ (If Yes, Worsening ❑ Improving ❑ Same ❑)
   Location of headache: Front ❑ Back ❑ Side of head (Right ❑ Left ❑ Both ❑)
   Behind eye ❑ Other ❑
   How would you describe your headache? Throbbing ❑ Achy ❑ Pressure ❑ Sharp ❑ Other ❑

3. **Other symptoms**

Dizziness ❑	Light-headedness ❑	Nausea ❑	Visual problems ❑	
Memory loss ❑	Vomiting ❑	Urinary problems ❑	Constipation ❑	Diarrhea ❑
Bleeding ❑	Paralysis ❑	Sleeplessness ❑	Restlessness ❑	Forgetful/foggy ❑
Numbness ❑	Tingling ❑	Disorientation ❑	Ringing /buzzing in ears ❑	
Decreased concentration ❑				

4. **After the accident, when did your symptoms begin?** Immediately ❑ Couple of hours later ❑
   Half a day later ❑ The next day ❑ 2 days later ❑ Other _____

5. **Seat belt on?** Yes ❑ No ❑
   Shoulder harness on? Yes ❑ No ❑

6. **How has your pain progressed since the accident?** Worse ❑ Same ❑ Improved ❑

7. **Where were you in the vehicle?** Driver ❑ Front right passenger ❑ Back left (behind driver) ❑
   Back right ❑ Other _____

8. **How was your head positioned at the time of the accident?**_____

9. **How was your body positioned at the time of the accident?**_____
If you were the driver, where was your right foot when the accident happened?
On the brake ❑ On the gas pedal ❑ Resting on the floor ❑ Bracing ❑

10. **What part of the car in which you were sitting was hit?** (Check ALL that apply.)
Front ❑ Rear ❑ Left side ❑ Right side ❑ Left corner ❑ Right corner ❑ Other ❑

11. **During the accident, how did your body move?** (Check ALL that apply.)
Violently jolted in seat ❑ Thrown forward ❑ Thrown backward ❑ Thrown left ❑ Thrown right ❑
Were you aware that the accident was about to happen? Yes ❑ No ❑
Were you braced for the impact? Yes ❑ No ❑

12. **Did any part of your body (<u>INCLUDING YOUR HEAD</u>) strike anything in/on the car?**
(Driver's door, windshield, gearshift, etc.)
A. Body part _____ struck _____
B. Body part _____ struck _____
C. Body part _____ struck _____

13. **Did you lose consciousness?** Yes ❑ No ❑ If Yes, for how long? _____
Do you/did you have amnesia? Yes ❑ No ❑

14. **Was your car stopped at the time of the accident?** Yes ❑ No ❑
If No, what was your speed? _____
The car was: Slowing down ❑ Gaining speed ❑ Driving at a steady rate ❑
Did the accident push/move your car? Yes ❑ No ❑
If Yes, in which direction? Forward ❑ Backward ❑ Sideways ❑ Diagonally ❑
How far were you pushed (approx)? _____
If pushed, did your car strike another car/object? Yes ❑ No ❑
If Yes, what?_____

15. **Were you seen at a hospital?** Yes ❑ No ❑ If Yes, how many hours after the accident?_____
Hospital name _____
How did you get to the hospital? _____
Were X-rays taken? Yes ❑ No ❑ _____
Medications prescribed at the hospital: Muscle relaxant ❑ Anti-inflammatory ❑ Painkiller ❑
Other medication(s) _____
Time off from work given? Yes ❑ No ❑ If Yes, from _____ to _____

16. **Please list any other doctors/healthcare providers seen since the accident**
A. Name _____ Address _____
Phone _____
Tests or treatment given _____
_____
B. Name _____ Address _____
Phone _____
Tests or treatment given _____
_____

17. **Previous accidents or significant injuries to areas injured in this accident**

A. Type of accident _____ Date _____
Area(s) injured _____
Did you recover completely? Yes ❑ No ❑ If No, explain _____
_____

B. Type of accident _____ Date _____
Area(s) injured _____
Did you recover completely? Yes ❑ No ❑ If No, explain _____
_____

C. Type of accident _____ Date _____
Area(s) injured _____
Did you recover completely? Yes ❑ No ❑ If No, explain _____
_____

18. **Were any of the areas injured in the present accident symptomatic before the accident?**
Yes ❑ No ❑ If Yes, explain _____
_____

I agree that all of the above information is correct and true to the best of my knowledge:

Print name Signature Date

(below for doctor's use)

WHOLE CHIROPRACTIC HEALTHCARE

Irrevocable Assignment of Benefits, Lien, & Authorization

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to **Whole Chiropractic Healthcare, LLC/Dr. Thomas K. Hyland Robertson** ("office"), such as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment, or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for services rendered refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name. I further authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as it sees fit.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien, & Authorization does not constitute any consideration for the office to await payments; the office may demand payments from me immediately upon rendering services, at its option. Such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, & Authorization. I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, individually, and/or my successors hereby waive any statute of limitation, defense of the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by Whole Chiropractic Healthcare, LLC, as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered. A photocopy of this agreement shall be considered as effective and valid as the original.

Date _____ Name _____

Signature _____

Witness signature _____

IF you have retained an attorney:
The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect the above-named doctor/office.

Date _____ Name _____

Attorney Signature _____

Insurance Information

_____

Name of **MY Auto Insurance Company** (or that of the driver of the car in which you were riding)

_____

Address City State Zip

_____

Claim Number Policy Number Name of Insured

_____

Name of **OTHER PARTY'S Auto Insurance Company**

_____

Address City State Zip

_____

Claim Number Policy Number Name of Insured