Family Chiropractic Center

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Auto Case Questionnaire

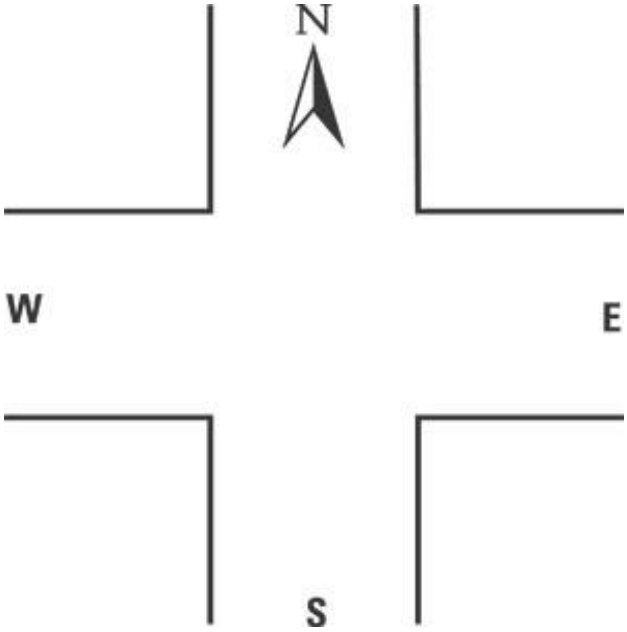
Patient Name: _____ Date: _____

Is this your first time seeing a Chiropractor: YES NO If yes, Dr's name:_____
Have you ever been treated to for back or neck injuries?: _____
Have you had previous treated injuries, for these same injured regions?: _____

Date of Injury: _____ Time of Injury: _____AM/PM
Street or Intersection where accident occurred: _____
City & State where accident occurred: _____
What direction were you traveling in? _____
What direction was the other car traveling? _____
Please give a brief description of the accident? _____
_____

How many vehicles were involved in the accident? _____
Make and Model of vehicle you were in: _____
What is the estimated damage to your vehicle? _____
Make and Model of other vehicle in accident: _____
What is the estimated damage of the other vehicle? _____

Please draw a diagram of the accident and the vehicles below.
Label the streets and with arrows show which direction each vehicle was moving.



What type of impact was the accident?
Front Side Rear
At the time of impact was your vehicle:
Slowing Down, Gaining Speed, Stopped, Moving at a Steady: _____mph
At the time of impact, the other vehicle was:
Slowing Down, Gaining Speed, Stopped, Moving at a Steady: _____mph

During and after the accident what happened to your vehicle? (Circle all the apply)
*Kept going straight, not hitting anything
*Kept going straight, hitting a car in front
*Was hit by another vehicle, where on car: _____
*Spun around and hit a stationary object: _____
*Hit a stationary object: _____
*Spun around

Did you know the accident was coming? NO YES
Did you brace yourself? NO YES
Were you relaxed before the accident? NO YES
Did you lose consciousness during the accident? NO YES
Were you intoxicated (alcohol) at the time of the accident? NO YES
Were you under the influence of prescription drugs? NO YES
Were you under the influence of over the counter medication? NO YES
Were you wearing your seat belt? NO YES
Did your seat belt have a shoulder harness? NO YES
Did you slide out of your seatbelt during the accident? NO YES

Where were you sitting in the vehicle during the accident? _____
How was your head positioned during the accident? _____
How was your torso positioned during the accident? _____
How were your hands positioned during the accident? _____

What kind of headrest was in your vehicle? Moveable Non-Movable No headrest
Where was your headrest positioned on your head? (Circle One)
At the top of the back of your head
Midway height of the back of your head
Lower height of the back of your head
Located at the level of your neck
Located at the level of you shoulder blades (upper back) below neck

Did your (blank) hit anything during the accident?
Head? NO YES, describe _____
Face? NO YES, describe _____
Shoulders? NO YES, describe _____
Neck? NO YES, describe _____
Arm/Hand? NO YES, describe _____
Chest? NO YES, describe _____
Hips? NO YES, describe _____
Knees? NO YES, describe _____

Leg? NO YES, describe _____
Foot? NO YES, describe _____
(Examples of things hit: Windshield, window, door, dashboard, glove compartment, seatbelt, frame of car near windows, roof of vehicle, another occupant, animal in the vehicle, head rest, steering wheel)

Did any of the structure of your vehicle dent inward during the crash? NO YES: _____
Did the side door touch your body during the crash? NO YES
Were there any doors that would not open as a result of the accident? NO YES, which: _____
Do you have any bruising on your body since the accident? NO YES, where: _____
Did you go to the emergency room afterward? NO YES, which: _____
Did you go to the emergency room the same day as the accident? NO YES
Did you go to emergency room in an ambulance? NO YES
Did you or another person drive yourself to the emergency room? NO YES
Were you hospitalized overnight? NO YES
Were X-Rays taken at the hospital or anywhere else? NO YES
Were you prescribed any pain medication or muscle relaxers? NO YES
Did you have any cuts or lacerations? NO YES
Did you require any stitches? NO YES
Were you given a neck collar or back brace to wear? NO YES

Have you been able to work since the accident? NO YES
Did you take any time off work? NO YES, From _____ To _____

When did you first notice any pain after the accident? _____
Did you follow up with any other doctors prior to coming to our office? NO YES, who:_____
If you did not see a doctor for the first time within the first week, indicate why? _____
_____

If you did not see a doctor for the first time within the first month after injury, indicate why? _____
_____

Please list all doctors, tests & treatment since accident in sequential order:
1) Name Hospital/Doctor/Therapist/Center: _____
Address, City, State: _____
Dates seen: _____
What was done: _____
Will you be following up with them? _____
Did treatment: Make condition worse Did not help Helped

2) Name Hospital/Doctor/Therapist/Center: _____
Address, City, State: _____
Dates seen: _____
What was done: _____
Will you be following up with them? _____
Did treatment: Make condition worse Did not help Helped

Please circle all that have already been done in relation to this accident:

X-Ray of Neck	X-Ray of Low Back	Other X-Rays	MRI/CT Scan
Rehabilitation	Physical Therapy	Ultrasound	Massage Therapy
Spinal Manipulations	Heat pack	Ice pack	Prescribed exercises

I understand that for treatment provided by Family Chiropractic Center related to this automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and authorize Family Chiropractic Center to bill PIP and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

Should PIP insurance not be available, exhaust or terminate for any reason, I authorize Family Chiropractic Center to bill any applicable health insurance I may have available, subject to any contract Family Chiropractic Center may have with such carrier. I understand and authorize Family Chiropractic Center to bill health insurance, if applicable, and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

I authorize Family Chiropractic Center to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand I may then be asked to make minimum monthly payment on any balance owed. I understand and acknowledge that in the event a medical lien in filed, and that if the lien is paid or sealed, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien with the County auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien, I further understand that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to Family Chiropractic Center for treatment provided, and I may be required to make additional payment after satisfaction of the lien.

Date this _____ day of _____, 20_____, at Mount Vernon, Washington

Patient Signature: _____

Did the Police come to the Scene and make a Report? NO YES
Where any Pictures taken of the Scene? NO YES
****

Have you Reported the Accident to **YOUR** Insurance Company? NO YES
Name of the insured on your vehicle: _____
Name of your Insurance Company _____ Claim#_____
Do you have PIP on your Insurance? NO YES Limit $ _____
Adjuster Name: _____
Billing Address_____ State_____ Zip_____
Phone # (_____) _____ Fax# (_____) _____
Email_____@_____.com
****

2nd Vehicle's driver Name: _____
Address_____ State_____ Zip_____
Phone # (_____) _____ Fax# (_____) _____
Email_____@_____.com

2nd Vehicle's Driver's Insurance Company_____
Address_____ State_____ Zip_____
Phone # (_____) _____ Fax# (_____) _____
Email_____@_____.com
Claim # with this insurance company: _____
****

Is an Attorney Representing you? NO YES
Name of the Firm? _____
Name of your Attorney: _____
Address_____ State_____ Zip_____
Phone # (_____) _____ Fax# (_____) _____
Email_____@_____.com
****

Thank you we appreciate the time you took to fill out all of our forms.
If you have any question or need help filling out anything please let our office staff know, we will be happy to help.

For Office Only
Notes_____
_____
_____
_____
_____
_____
_____
_____
Lien status
Date Sent ___/___/20_____ Date Received ___/____/20_____ Date to Resend ____/___/20_____