

## Motor Vehicle Accident Insurance Questionnaire

Name: \_\_\_\_\_ Accident Date: \_\_\_\_\_

State accident occurred in: \_\_\_\_\_

1. Has the accident been reported to the police? Y / N      If yes, were they at the accident scene? Y / N      If yes, was anyone cited? Y / N  
     If yes, whom? ( ) Myself ( ) My Driver ( ) The other driver ( ) Other \_\_\_\_\_
2. Have you retained an attorney? Y / N      If yes, name of your attorney: \_\_\_\_\_  
     Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
     City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
     Phone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_
3. Have you reported the accident to any insurance company? Y / N  
     If yes, which one(s)? ( ) My own ( ) My driver's ( ) The owner of the vehicle I was in  
     ( ) the other driver's ( ) The owner of the other driver's vehicle
4. Were you in your own vehicle at the time of the accident? Y / N      If yes, skip to Box 2.

**BOX 1 – Information about the vehicle you were in, if it was NOT your own.**

Insured's Name: _____	Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insured's address: _____	
Insured's Phone#: ( ) _____	Insurance Co Phone #: ( ) _____
Ins Co for the vehicle you were in: _____	Policy #: _____
Medical Adjuster's Name: _____	Claim #: _____
Medical Adjuster's Phone #: ( ) _____	Ext.: _____
Insurance Billing Address: _____	Attn: _____

**BOX 2 – Your vehicle information: (Regardless if you were in someone else's vehicle at the time)**

Insured's Name: _____	Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insured's address: _____	
Insured's Phone#: ( ) _____	Insurance Co Phone #: ( ) _____
Ins Co for the vehicle you were in: _____	Policy #: _____
Medical Adjuster's Name: _____	Claim #: _____
Medical Adjuster's Phone #: ( ) _____	Ext.: _____
Insurance Billing Address: _____	Attn: _____

**BOX 3 – Information pertaining to the person that hit you:**

Insured's Name: _____	Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insured's address: _____	
Insured's Phone#: ( ) _____	Insurance Co Phone #: ( ) _____
Ins Co for the vehicle you were in: _____	Policy #: _____
Medical Adjuster's Name: _____	Claim #: _____
Medical Adjuster's Phone #: ( ) _____	Ext.: _____
Insurance Billing Address: _____	Attn: _____

5. Have you received the Personal Injury Protection forms from your insurance company? Y / N  
     If yes, have you returned them to the insurance company? Y / N      Do you have a copy? Y / N

The information given in this questionnaire is true to the best of my knowledge.

 \_\_\_\_\_  
 Patient / Guardian Signature

 \_\_\_\_\_  
 Witness Signature

 \_\_\_\_\_  
 Today's Date

# Automobile Accident History

Date: \_\_\_\_\_

Patient # \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Email \_\_\_\_\_ May we send you our online newsletter? yes no

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Business/Employer \_\_\_\_\_ Spouse Phone: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_ Walk In Advertisement Promotion Yellow Pages

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 If yes, was the driver's foot on the brake?  yes  no If no, estimate the speed of the vehicle you were in: \_\_\_\_\_ mph

If 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.**

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

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

1\* 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? \_\_\_\_\_

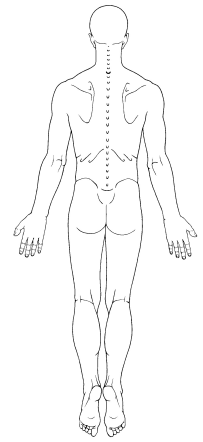
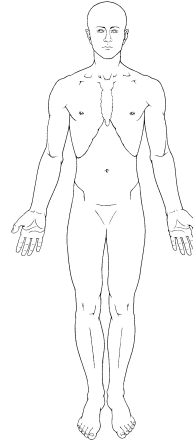
Type of pain?  Sharp  Dull  Aching  Burn  Throb  Numb  Other \_\_\_\_\_

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



2\* 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? \_\_\_\_\_

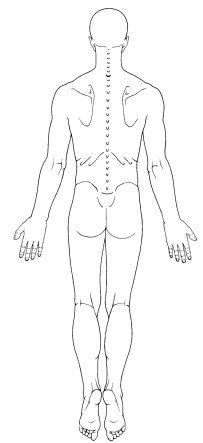
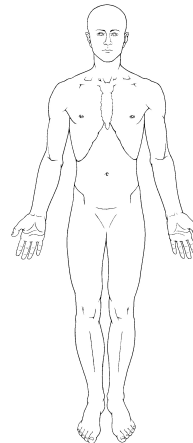
Type of pain?  Sharp  Dull  Aching  Burn  Throb  Numb  Other \_\_\_\_\_

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



3\* 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? \_\_\_\_\_

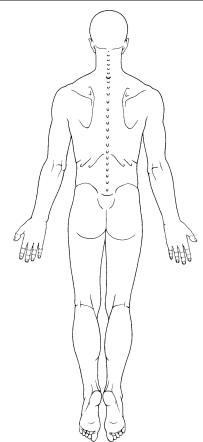
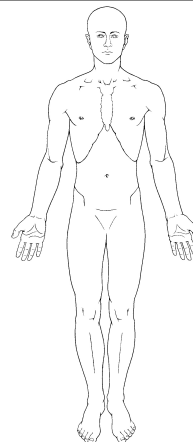
Type of pain?  Sharp  Dull  Aching  Burn  Throb  Numb  Other \_\_\_\_\_

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



**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. \_\_\_\_\_

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: \_\_\_\_\_

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

\_\_\_\_\_ Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_ What is this for? \_\_\_\_\_

\_\_\_\_\_ Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_ What is this for? \_\_\_\_\_

\_\_\_\_\_ Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_ What is this for? \_\_\_\_\_

\_\_\_\_\_ Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_ What is this for? \_\_\_\_\_

**X-RAY CONFIRMATION - FEMALES**

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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

**AUTHORIZATION FOR CARE OF MINOR**

CONSENT TO TREAT A MINOR: I hereby 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: \_\_\_\_\_