

MOTOR VEHICLE ACCIDENT PATIENT FORM

**Please answer all the questions completely. All information provided is strictly confidential.
If you do not understand a question or are unsure of the information, please ask for assistance.**

Patient Name: _____ Date: _____
In the accident, you were the: DRIVER PASSENGER PEDESTRIAN/CYCLIST OTHER
Date of Injury: _____ Time of Injury: _____ AM PM
City where crash occurred: _____ Was the street wet or dry? Wet Dry
Street (location) where accident occurred: _____
What is the estimated damage to your vehicle? \$ _____
Who made damage estimates on your vehicle? _____
Who owns the vehicle you were involved in? _____
Did the police come to the accident scene? Yes No
Did the police make a written report? Yes No If yes, report number if known: _____
Were photographs taken of your vehicle? Yes No If yes, who took them: _____
Do you have automobile medical insurance coverage? Yes No Company Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____
Have you reported this injury to your car insurance company? Yes No
Adjuster's Name: _____ Phone: _____
Policy #: _____ Claim #: _____
Is an attorney representing you? Yes No Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____
Have you been in a motor vehicle accident before? Yes No If yes, when? _____

DESCRIBE HOW THE CRASH HAPPENED:

COLLISION DESCRIPTION:

Check all that apply to you. Indicate which type of automobile accident you were involved in:
 Single-car crash Two-vehicle crash Three or more vehicles
 Rear-end crash Side crash Rollover
 Head-on crash Hit guard rail, tree, or object Ran off the road
 Other (Describe): _____

DESCRIBE THE VEHICLE YOU WERE IN:

Make: _____ Model: _____ Year: _____
 Small-sized car Mid-sized car Large-sized car
 Pick-up truck Van Sport Utility Vehicle
 2 Door vehicle 4 Door vehicle Large truck, bus, semi-truck
 Sedan Hatchback Station wagon

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DESCRIBE THE OTHER VEHICLE:

Make: _____ Model: _____ Year: _____ unknown

Small car Mid-sized car Van

Pick-up truck/sports utility Full-sized car Large truck, bus, semi-truck

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

Slowing down Gaining speed Stopped, brake engaged Stopped, no brake Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

Slowing down Gaining speed Unknown speed Stopped Moving at steady speed Other

DURING AND AFTER THE CRASH, YOUR VEHICLE:

Kept going straight, not hitting anything Spun around, not hitting anything

Kept going straight, hitting car in front Spun around, hitting another car

Was hit by another vehicle Spun around, hitting object other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: (Please draw lines from the body regions on the left side and match to the right side.)

BODY REGION

OBJECT YOU HAD CONTACT WITH

Head

Face

Shoulder

Arm/Hand

Front chest wall

Side chest wall

Hip/Abdomen

Knee

Leg

Foot

Windshield

Side Window

Side Door

Dashboard

Knee bolster/Glove compartment

Seatbelt

Frame of car near windows

Roof of window

Another occupant/Animal

Roof

Steering wheel/Column

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

Windshield

Seat frame

Knee bolster

Steering wheel

Side or rear window

Brake pedal

Dash

Mirror

Other

ALL TYPES OF COLLISIONS (Indicate those relevant to your case):

YES NO Did any of the front or side structures, such as the side door, dashboard, or floorboard of your

Car dent inward during the crash?

Did the side door touch your body during the crash?

Was the door(s) of your vehicle damaged to a point where you could not open the door?

Did your body slide under the seatbelt?

Did an airbag deploy in your vehicle during the crash?

Were you intoxicated (alcohol) at the time of the crash?

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SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

- Were you wearing a seatbelt?

If yes, does your seatbelt have a: Lap and shoulder strap, Lap belt only

- Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
 Were you holding onto the steering wheel (driver only) at the time of impact?

If yes, indicate where each hand was positioned (Use time clock face as your reference point)

Left hand: Not on wheel, Yes, hand at ___ o'clock, Hand elsewhere

Right hand: Not on wheel, Yes, hand at ___ o'clock, Hand elsewhere

REAR-END COLLISIONS ONLY (Answer this section only if you were hit from the rear):

Describe your vehicle's head restraint system:

- Movable/adjustable head restraint Fixed, non-movable head restraint
 No headrests in my vehicle Bench seat in your vehicle without head restraint

Please indicate how your head restraint was positioned at the time of crash (if present):

- 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 the neck
 Level of your shoulder blade

Estimated distance between back of head and front of headrest: _____

BRUISING AFTER THE CRASH:

YES NO

- Did your body have any bruising (areas that were visibly black and blue) after the crash?

If yes indicate where: _____

AWARENESS AND BODY POSITION DESCRIPTIONS (Check all areas that apply to you):

- You were **unaware** of the impending collision. You did **not** see or hear brakes prior to the impact.
 You were **aware** of the impending crash and relaxed before the collision.
 You were **aware** of the impending crash and braced yourself.
 Your body, torso, and head were facing straight ahead.
 You had your head and/or torso turned at the time of collision: Turned to the left, Turned to the right

Describe how far you were turned/twisted and why?

- You were leaning forward at the time of impact resulting in a gap between your body and the seatback.
 Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

EMERGENCY ROOM AND DISABILITY DATES:

YES NO

- Did you go to the emergency room afterward? If yes, date and time: _____
Name of the emergency room? _____ City: _____
 Did you go to the emergency room in the ambulance?
If yes, name of ambulance company: _____
 Did you or another person drive you to the emergency room?
Name of person: _____

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YES NO

- Were you hospitalized after being seen in Emergency Room?
If yes, how many days: _____
- Did the emergency room doctor take X-rays? Check what regions x-rays were taken:
 - Skull/Face x-rays Ribs/Chest
 - Neck or Middle back x-rays Collar bone
 - Low back or Hip/Pelvis x-rays Shoulder, Arm or Hand
 - Leg or Foot Other
- Did the hospital or clinic take MRI or CT of your body? If yes, indicate where taken:
 - Skull Neck Low back or hip/pelvis other
- Did you have any broken bones/fractures? If yes, where: _____
- Did you have a cast put on for any sprain or fracture? If yes, type/location: _____
- Did you have any dislocations? If yes, where: _____
- Did you have any cuts or lacerations? If yes, where: _____
- Did you have any skin abrasions? If yes, where: _____
- Did you require any stitching for cuts? If yes, where: _____
- Did you have any visible bruises or lumps? If yes, where: _____
- Did you have any visible bruises along the shoulder or lap portions of your seatbelt?
- Did the Emergency Room doctor give you any pain medications?
- Did the Emergency Room doctor give you any muscle relaxants?
- Did the Emergency Room doctor give you any other medications/prescriptions?
If yes, what were the medications and dosages? _____
- Were you told you had a herniated or bulging disc in your neck or back?
If yes, where: _____
- Were you given a neck collar or back brace to wear?
- Did you require any surgery after the accident?
If yes, describe type and date: _____
- Were you hospitalized overnight? If yes, indicate dates hospitalized: _____

HOW SOON DID YOU FIRST NOTICE ANY PAIN OR SORENESS AFTER YOU YOUR INJURY?:

- Less than 24 hours after injury Began 1-7 days after injury Began ___ days after injury

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME UNTIL AFTER TWO WEEKS FROM THE INJURY DATE, INDICATE WHY: (Check all that apply only if you had delay in seeing a doctor)

- No pain was noticed
- No appointment schedule available
- Thought pain would go away
- No transportation
- Work/home schedule conflicts
- Other: _____

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DISABILITY: HAVE YOU BEEN ABLE TO WORK SINCE INJURY?

YES NO Have you lost days off work? If yes, you were off work: Partially Completely

Please list all dates off work: From: _____ to _____.

If you had neck and/or back pain so severe that you were unable to get out of bed, how many hours after the accident did you develop this disabling level of pain? _____

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom does not apply to you.

SYMPTOM LIST	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS CURRENTLY	HAD SIMILAR SYMPTOMS WITHIN ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of leg				
Knee pain				
Ankle/foot pain				

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PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN:

Start with the first doctor you went to after your injury or condition began and list all providers (all types of doctors or therapists) up to your last provider seen and check all that apply for each. Be certain to list these in sequence from first to last.

(1) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- Exam-consultation Rehabilitation Exercises
- IME exam or consult only Ultrasound Acupuncture
- X-ray of neck Spinal adjustments Injection (s)
- X-ray of chest/mid back Muscle massage/myotherapy Wrist brace-splint
- X-ray of low back Muscle stimulation Neck collar (brace)
- Other X-rays Physical therapy Low back brace
- MRI/CT scan Anti-inflammatory medications Heat packs
- EMG/ Nerve conduction study Pain medications Ice packs
- Other tests Muscle relaxants Other

Indicate if treatment with this provider: Helped Did not help Other

(2) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- Exam-consultation Rehabilitation Exercises
- IME exam or consult only Ultrasound Acupuncture
- X-ray of neck Spinal adjustments Injection (s)
- X-ray of chest/mid back Muscle massage/myotherapy Wrist brace-splint
- X-ray of low back Muscle stimulation Neck collar (brace)
- Other X-rays Physical therapy Low back brace
- MRI/CT scan Anti-inflammatory medications Heat packs
- EMG/ Nerve conduction study Pain medications Ice packs
- Other tests Muscle relaxants Other

Indicate if treatment with this provider: Helped Did not help Other

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(3) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- Exam-consultation Rehabilitation Exercises
- IME exam or consult only Ultrasound Acupuncture
- X-ray of neck Spinal adjustments Injection (s)
- X-ray of chest/mid back Muscle massage/myotherapy Wrist brace-splint
- X-ray of low back Muscle stimulation Neck collar (brace)
- Other X-rays Physical therapy Low back brace
- MRI/CT scan Anti-inflammatory medications Heat packs
- EMG/ Nerve conduction study Pain medications Ice packs
- Other tests Muscle relaxants Other

Indicate if treatment with this provider: Helped Did not help Other

Thank you for completing this questionnaire and intake form regarding your recent accident and injury.
The information provided will help us create the most effective treatment for your rapid improvement.



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ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or am about to receive) healthcare services at the Sylvan Chiropractic Clinic and Wellness Center, LLC, and that I have been advised that the doctor(s) providing the services is (are) willing to wait for payment for these services, provided that there continues to be reasonable certainty that payment will be made either by insurance proceeds or out of the settlement of liability.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or
2. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or I have not engaged in the services of an attorney, then payment for services rendered by the doctor(s) at the Sylvan Chiropractic Clinic and Wellness Center, LLC, will be made by me on a current basis and my bill will be paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

In the event that a settlement pays less than 100% of the invoiced amount from the Sylvan Chiropractic Clinic and Wellness Center, LLC due to a diminished fee being offered by my attorney at any point, I am responsible for the balance owed to the Sylvan Chiropractic Clinic and Wellness Center, LLC, and arrangements for payment will be made accordingly in no less than thirty days.

Dated the _____ day of _____, 20_____.

Patient's Name _____

Patient's Signature _____

Witness _____