AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

Your position in the vehicle:

❑Driver
❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at apprx ____MPH
❑Moving Slowly

Why Vehicle was slowed or stopped:

❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:

❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

❑Full daylight
❑Dusk
❑Night

Road Conditions:

❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:

❑Excellent
❑Good
❑Fair
❑Poor

Visibility compromised by:

❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

❑Seat belt
❑Shoulder harness
❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

❑Car not equipped with air bag
❑Air bag deployed
❑Air bag not deployed

What position was YOUR headrest in?

❑High position
❑Middle position
❑ Low position

Position of YOUR head at time of impact?

- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?

- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?

- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?

- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:

- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:

- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

*THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

❑Yes
❑No

Immediately following the accident, did you feel...?

❑Dizzy ❑Weak
❑Dazed ❑Nervous
❑Disoriented ❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

❑Drove home ❑Drove to work
❑Was driven home ❑Was driven to work
❑Drove to hospital ❑Drove to school
❑Was driven to hospital ❑Was driven to school
❑Taken to hospital via ambulance

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑ Low Back ❑Pelvis

Have you seen any previous health care providers for this accident?

Name of Dr./Therapist	Date of Treatment	Purpose of Results
1.		
2.		
3.		

Have you had any previous accidents for which any treatment was provided? List most recent first:

1.

2.

3.

Have you ever had back or neck pain that required treatment? Please describe in detail:

Do you have any significant health problems? (muscular, nerve system, vascular, digestive)

Are you taking any medications? Please list what and what for:

At the time of the accident, were you working? Please list dates of work missed due to accident

Have you retained an attorney?

If yes, Name and address_____

_____

Do you authorize us to send your attorney medical records?

If yes, please sign and date:_____

AUTHORIZATION TO PAY PHYSICIAN

Patient: _____

Claim/Group #:_____

Date of Injury: _____

I hereby instruct and direct the _____Insurance company to pay by check made out and mailed directly to:

Block Chiropractic and Rehabilitation Center, LLC

3919 National Drive, Suite 110

Burtonsville, MD 20866

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/o Block Chiropractic and Rehabilitation Center, LLC

3919 National Drive, Suite 110

Burtonsville, MD 20866

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date: _____

Signature of Claimant: _____

Witness: _____

Signature of Claimant, if other than Policyholder: _____

DOCTORS LIEN

To: Attorney

_____

_____

_____

Phone: _____

From: **Block Chiropractic and Rehabilitation Center**

3919 National Drive, Suite 110

Burtonsville, MD 20866

Telephone: (301) 476-7575

Fax (301) 476-7730

Records

I authorize the above-named doctor/clinic to furnish to the above named attorney all information provided by or pertaining to me, including all records relating to the above-named doctor's/clinic examination, diagnosis, treatment, prognosis, etc.

Doctor's/Clinic's Lien

I authorize and direct the above-named attorney to withhold from any disability, medical, no-fault, health, accident, worker's compensation benefits, or any other benefits, insurance or reimbursement which may be payable to me or for my benefit arising from the condition for which I have been treated or received services, any amount as may be necessary to pay for such treatment or service, and to pay any amount which may be due and owing to the above-named doctor/clinic.

Responsibility for Payment

I agree that I am personally responsible for prompt payment to the above-named doctor/clinic of all amounts that may be due and owing for treatment or services rendered to me for my benefit, that payment shall not be contingent upon the payment upon the payment to me of any benefit, insurance or reimbursement by any other party, and that the lien and direction to pay contained in the preceding paragraph is solely as additional security to the above –named doctor/clinic.

Cost of Collection

I agree that if any amount due and owing to the above-named doctor/clinic for treatment or services performed for me is not paid when due, interest and collection costs, including attorney fees, will be added to the amount due.

Waiver

I specifically waive any claim of privilege with respect to the disclosure by the above-named doctor/clinic to the above-named attorney of information provided by or pertaining to me, which I specifically authorize to be disclosed.

Date: _____ Patient's Signature: _____

Date of Injury/Illness: _____ Print Name: _____

Acknowledgement

The undersigned attorney acknowledges receipt of notice of lien of the above named doctor-clinic, and agrees to withhold from any payment of benefits, insurance or reimbursement, and make payment of any amount as may be due and owing to the above-named doctor/clinic for treatment or services of the Patient directly to the above-named doctor/clinic.

Date: _____ Attorney's Signature: _____

Attorney: Please date, sign, and return a copy to the above named doctor/clinic in the attached reply envelope. Keep one copy for your records.

PERSONAL INJURY INSURANCE INFORMATION

WHAT IS THE MAKE AND YEAR OF THE VEHICLE YOU WERE IN? _____

_____

NAME OF THE OWNER?_____ DRIVER?_____

NAME OF THE INSURANCE COMPANY OF THE ABOVE CAR? _____

ADDRESS OF INS. CO.?_____

PHONE # OF INS. CO.?_____ ADJUSTERS NAME?_____

POLICY # _____ CLAIM # _____

WHAT IS THE MAKE AND YEAR OF THE VEHICLE THAT **HIT YOU**?_____

_____

NAME OF THE OWNER?_____ DRIVER?_____

NAME OF THE INSURANCE COMPANY OF THE ABOVE CAR?_____

ADDRESS OF INS. CO.?_____

PHONE # OF INS. CO. _____ ADJUSTERS NAME _____

POLICY # _____ CLAIM # _____

WHAT IS YOUR ATTORNEY'S NAME? _____

THEIR ADDRESS _____

PHONE # _____ HAVE YOU SIGNED PAPERS?_____

WHAT IS YOUR HEALTH INSURANCE CO.?_____

POLICY # _____ GROUP # _____ SS # _____

INS. CO. ADDRESS _____

PHONE # OF INS. CO. _____