

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) ARE OR WERE 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 (INCLUDING YOUR HEAD) 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 _____

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 _____

