Automobile Accident Questionnaire

No Fault Insurance Information—<u>All information in this box is REQUIRED</u>.
If any information is missing, we may reschedule your appointment until you obtain all information needed to bill your insurance. **We are unable to treat patients who do not have claim numbers.**

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

Date of Accident: _____

Were you working on the clock at the time of the accident? (Circle) Yes / No

Policy Holder's Name: _____

Claim #:_____

Claims Adjuster's Name _____

Claims Adjuster's Phone Number: _____

Insurance Company Name: _____

1. Driver of car: _____ Where you were seated:_____

2. Owner of car: _____ Year and Model of car:_____

4. Road conditions / visibility at time of accident (circle): icy / rainy / wet / clear / dark / other: _____

5. Where was your car struck? (circle) right / left / rear / front / side / other: _____

6. Type of accident: (circle) head-on collision / broad-side collision / rear-end collision

front impact, rear-ended car in front / non-collision: _____

7. Describe what happened to you upon impact? _____

8. Did you see the accident was about to happen? (Circle) Yes / No

10. Were you wearing a seatbelt? (Circle) Yes / No

12. Was your car braking? (Circle) Yes / No Was the other car braking? (Circle) Yes / No

13. Was your car moving at the time of the accident (Circle) Yes / No Estimated Speed _____

14. How fast would you estimate the other car was traveling? _____

16. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

17. As a result of the accident were you: (Circle) rendered unconscious / dazed / other: _____

18. Could you move all parts of your body? (Circle) Yes / No

If no, why not? _____

19. Were you able to get out of the car and walk unaided? (Circle) Yes / No

If no, why not? _____

20. Did you have any cuts or bruises from this accident? (Circle) Yes / No

If so, where? _____

22. Check symptoms apparent <u>since</u> the accident:

☐ headache	☐ loss of smell	☐ numbness in fingers	☐ neck pain/stiffness
☐ loss of taste	☐ cold hands	☐ mid-back pain	☐ loss of memory
☐ cold feet	☐ low-back pain	☐ fatigue	☐ diarrhea
☐ tension	☐ constipation	☐ pain behind eyes	☐ shortness of breath
☐ chest pain	☐ dizziness	☐ irritability	☐ nervousness
☐ fainting	☐ depression	☐ cold sweats	☐ anxious
☐ sleeping problems	☐ loss of balance	☐ numbness in toes	☐ ringing/buzzing in ears
☐ eyes sensitive to light	☐ other: _____		

23. Have you missed time from work? (Circle) Yes / No Work hours are: (Circle) full-time / part-time

If you have missed time from work, how much time have you missed? _____

25. Did you seek medical help immediately/soon after the accident? (Circle) Yes / No

If yes, how did you get there? _____

26. Doctor/hospital/clinic seen: _____ Date: _____

Were x-rays taken? (Circle) Yes / No If yes, of what body part? _____

28. What treatments/prescriptions were given? (Circle) bed rest / brace / adjustments / medications

30. Date of last treatment: _____

31. Are any of your activities of daily living any different now compared to before the accident? (Circle) Yes / No

List anything you are unable to do: _____

34. Do you have an attorney handling this case? (Circle) Yes / No

If yes, who? (name/address) _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Cerniglia Chiropractic** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **Cerniglia Chiropractic** the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay **Cerniglia Chiropractic** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____