Tilson Chiropractic FamilyCare

Vehicle Accident Information

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

1. Accident Information

Date of Accident:_____Time of Accident:_____ □ a.m. □ p.m.
Make and model of vehicle you were in:_____ Year:_____
Number of people were in the accident vehicle___
Was the accident on the job? □ Yes □ No Were you in a company vehicle? □ Yes □ No
Road conditions at time of accident: □ Wet □ Dry □ Snow □ Ice □ Other_____
Road/ Street Name_____ City/State_____
Nearest Intersection_____ Direction Headed?_____ Speed traveled?_____
Did the police come to the accident scene? □ Yes □ No
Is there a police report? □ Yes □ No (Please bring police report to front desk to be copied)
Has anyone received a citation of violation? If so, who and for what?_____
Please describe, to the best of your knowledge, what happened during the accident:

_____
_____
_____

2. Impact

Were you the: □ Drive □ Front Passenger □ Rear Passenger □ Pedestrian
Were you: □ Braced for impact □ Surprised by impact
Did the car impact another vehicle? □ Yes □ No Did your car impact a structure? □ No □ Yes, Explain_____
Was the impact from: □ Front □ Rear □ Left □ Right
At the time of impact, in which direction was your **head** facing? □ Straight ahead □ Left □ Right □ Up □ Down □ Back
At the time of impact, in which direction was your **body** facing? □ Straight ahead □ Left □ Right □ Up □ Down □ Back
Which hands were on the steering wheel? □ Left □ Right □ Both □ None
Was your foot on the brake? □ Yes □ No If no, was your vehicle □ Slowing Down □ Gaining Speed □ Steady Speed
Were you wearing a seatbelt? □ Yes □ No If yes, did you receive any injury or bruise from the seatbelt? □ Yes □ No
Did your head hit the headrest on impact? □ Yes □ No What position was the headrest? □ Low □ Middle □ High
Did the airbag deploy? □ Yes □ No If yes, did it strike you? □ No □ Yes, where?_____
Did any part of your body strike anything in the vehicle? □ No □ Yes, explain_____
Were you unconscious immediately after the accident? □ No □ Yes, for how long?_____
Please describe how you felt immediately after the accident:

_____
_____
_____

3. Other Vehicle

Make and model of other vehicle:_____ Year:_____
Direction Headed?_____ Speed traveled?_____
At time of impact was the other vehicle: □ Slowing Down □ Gaining Speed □ Steady Speed

4. Treatment

Did you go to the hospital? □ Yes □ No If yes, when? □ Immediately □___ Hours later □___ Days Later
How did you get to the hospital? □ Ambulance □ Private transportation
Name of hospital:_____ Name of doctor:_____Duration of stay:____ days
Areas that were x-rayed: _____Diagnosis:_____

Was there any other doctor you consulted after your accident? □ Yes □ No If yes, please complete area 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:_____

5. Symptoms/ Injuries

Have you been able to work since this injury? □ Yes □ No How many days have you missed?_____

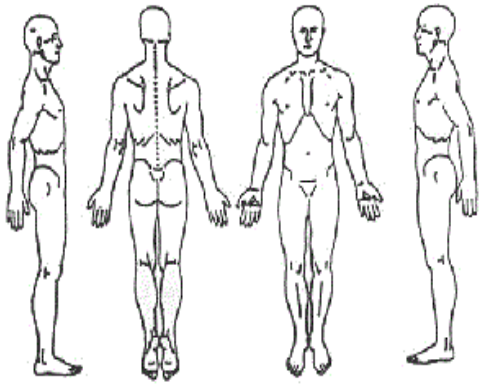
Please checkmark if you have had any of the following symptoms since your injury:

□ Arm/ Leg Pain	□ Fainting	□ Loss of Sleep	□ Sciatica
□ Back Pain	□ Fatigue	□ Loss of Smell	□ Shoulder Pain
□ Chest Pain	□ Fever	□ Menstrual Problems	□ Sinus Pain
□ Cold Hands/ Feet	□ Headaches/ Migraines	□ Nausea	□ Sore Muscles
□ Depression	□ Insomnia	□ Neck Pain	□ Tension
□ Difficulty Swallowing	□ Irritability	□ Nervousness	□ Upset Stomach
□ Digestive Problems	□ Jaw Pain/ Clicking	□ Numbness/ Tingling	□ Urinary Problems
□ Dizziness	□ Joint Pain/ Stiffness	□ Paralysis	□ Vision Problems
□ Ear Buzzing	□ Loss of Balance	□ Pinched Nerve	□ Other:_____
□ Ear Ringing	□ Loss of Memory	□ Pins/ Needles Feeling	_____

When did your symptoms appear? _____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching

□ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Is there anything you can do to relieve the problem? □ If No, what have you tried?_____

□ If Yes, describe:_____ What makes the problem worse?_____

6. Auto Insurance Information

Vehicle You Were In

Name of Driver:_____

Name of Auto Insurance Company:_____

Auto Insurance Phone:_____

Policy #:_____ Claim #:_____

Adjustor:_____ Phone_____

Driver of Other Vehicle

Name of Driver:_____

Name of Auto Insurance Company:_____

Auto Insurance Phone:_____

Policy #:_____ Claim #:_____

Adjustor:_____ Phone_____

7. Attorney

Have you retained an Attorney for this case? □ Yes □ No

Attorney's name:_____

Address:_____

Phone:_____Email:_____

8. Patient Information

Date:_____

Last Name_____

First Name_____(MI)_____

Address_____

City_____

State_____Zip_____

Phone (Cell)_____(Home)_____

Email_____

Sex: □ Female □ Male Age_____

Birth Date_____SSN:_____

Assignment of Payment and Authorization

By signing below, I hereby request and authorize direct payment to Tilson Chiropractic FamilyCare (TCF) any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay TCF 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 TCF 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. I authorize TCF to release any information to my insurance company, adjustor, or attorney that will assist in the process of the claim.

_____

Patient's Signature Date