ACCIDENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name _____ **Date** _____
Address _____
City _____ **State** _____ **Zip Code** _____
DOB _____**Age**_____ **SS#** _____**Marital Status** _____
Sex □ Male □ Female **How did you hear about the office?** _____
Home Phone _____ **Work Phone** _____
Employer _____ **Occupation** _____
Have you missed any days at work? □ Yes □ No **Dates Missed:** _____
Date of Accident _____ **Time of Accident** _____**AM/PM**
Please Describe the accident in your own words:_____
_____
_____
_____
Were you the: □ **Driver** □ **Front Passenger** □ **Rear Passenger** □ **Pedestrian**

ACCIDENT SITE

Road/Street Name _____
City/State _____
Driving Conditions: □ Dry □ Wet □ Icy □ Other
Visibility: □ Poor □ Fair □ Good □ Other_____
Was your vehicle moving? □ Yes □ No
Speed of you vehicle: _____**mph**

YOUR VEHICLE

Make and model of your car:_____
Were you wearing a seatbelt? □ Yes □ No
Were shoulder harnesses worn? □ Yes □ No
Did the airbag inflate? □ Yes □ No
Did your seat have a headrest? □ Yes □ No
If yes, what was the position of the headrest?
□ Top of headrest even with **bottom** of head
□ Top of headrest even with **top** of head
□ Top of headrest even with **middle** of neck

OTHER VEHICLE

Make and model other vehicle _____
Speed of other vehicle _____**mph**

IMPACT

Did your car impact another vehicle? □ Yes □ No
Did your body strike anything inside the vehicle?
□ No □ Yes, explain_____
Type of Impact: □ Front □ Rear □ Left
□ Right □ Other _____
How were you sitting before impact?
□ Head straight forward □ Body Straight
□ Head up/down □ Body Rotated right/left
□ Head turned right/left □ Other
Did you see the accident coming? □ Yes □ No
Did you brace for impact? □ Yes □ No
Was your car braking? □ Yes □ No

ILLUSTRATION OF THE ACCIDENT

PATIENT CONDITON

Were you unconscious after the accident? □ Yes □ No **If yes, for how long?**_____

Could you move all parts of your body? □ Yes □ No **If no, which parts couldn't you move and why?**_____

Were you able to get out of the car and walk unaided? □ Yes □ No, why not? _____

Did you get any bleeding cuts? □ Yes □ No **If yes, where?**_____

Did you get any bruises? □ Yes □ No **If yes, where?** _____

Please describe how you felt, 1) immediately after the accident?_____

2) Later that day?_____

3) The next day?_____

TREATMENT

Did you go to the hospital immediately after the accident? □ Yes □ No

How did you get there? □ ambulance □ police □ someone else drove me □ drove own car

When did you go? □ Immediately after the accident □ Next day □ 2 days or more after the accident

Hospital Name: _____ **Name of Doctor :** _____

Treatment received: _____

Medications given: _____

X-rays taken: _____

Did you seek any additional treatment? □ Yes □ No **If yes, who did you see?** _____

Date of visit?_____ **Treatment received:** _____

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

□ **Arm/Shoulder pain**	□ **Foot/toe numbness**	□ **Dizziness**
□ **Low back pain**	□ **Neck stiffness**	□ **Ear ringing**
□ **Neck pain**	□ **Headaches**	□ **Memory Loss**
□ **Upper back pain**	□ **Irritability**	□ **Jaw problems**
□ **Chest pain**	□ **Nausea**	□ **Sleep difficulty**
□ **Leg pain**	□ **Stomach upset**	□ **Blurred vision**
□ **Hand/finger numbness**	□ **Chest pain**	□ **Shortness of breath**

Past health history: Place an x if it applies and describe:

□ None related to current complaints	□ Hospitalized	□ Surgery
□ Other auto accident(s)	□ Work Accident	□ Illness

Describe condition and treatment:_____

_____

_____

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please circle the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?

1. High Blood Pressure (hypertension) □ Yes □ No
2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
3. Diabetes □ Yes □ No
4. Heart or blood vessel diseases □ Yes □ No
5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
7. Have any of your relatives suffered a stroke? □ Yes □ No
8. Were you ever a smoker? If yes, from _____ to _____ □ Yes □ No
9. Do you take any medications on a regular basis? □ Yes □ No
   - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)
     _____
10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
    - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?

1. Blurred Vision □ Yes □ No
2. Double Vision □ Yes □ No
3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
4. Complete loss of vision in one or both eyes? □ Yes □ No
5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
6. Hearing loss in one or both ears? □ Yes □ No
7. Slurred speech or other speech problems? □ Yes □ No
8. Difficulty swallowing? □ Yes □ No
9. Dizziness? □ Yes □ No
10. Temporary lack of understanding? □ Yes □ No
11. Loss on consciousness, even momentary blackouts? □ Yes □ No
12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
13. Any other abnormal sensations in any part of your body? □ Yes □ No
14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
15. Sudden collapse without loss of consciousness? □ Yes □ No

Patient Signature _____ Date _____

healthcarecomplete

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Release of Patient Information

Patient Name (print) _____ Date of Birth: _____

Authorized Release of Records to Primary Care Physician

I hereby authorize Healthcare Complete to release health care information regarding my treatment to the PCP listed below. I understand that records may be released while I am under care per my request to my PCP.

Primary Care Provider Information

Doctor Name/Practice Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

Authorized Release of Medical Records from other Providers

I hereby authorize Healthcare Complete to obtain any of the following medical records from my previous or concurrent medical providers: X-ray, MRI, CT films and reports, SOAP notes, prescriptions, lab tests and any other necessary medical records.

I hereby authorize the following medical facilities to release medical information pertinent to the management of my health.

Doctor Name/Facility Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

Dear Patient,

It is our desire that you have as pleasant an experience in our office as possible. Our most important concern is your health but we do need to do certain things to ensure that your personal injury bills will be taken care of. The following are a list of things all persons involved in an auto accident need to know about.

Please read the following and sign the bottom of this form.

1. *If the car is insured in MA:* YOUR insurance company is responsible for paying your bills, NOT the company of the person who hit you. If the accident was someone else's fault your insurance company will seek compensation from their insurance company. After the first $2,000.00 of total Personal Injury Protection (PIP) benefits are paid out, by law we must bill your health carrier. If your health carrier does not provide chiropractic benefit or if you do not have health insurance your PIP company will continue to pay your bills up to a total of $8,000.00.
2. *If the car is insured in NH*: you have the option of submitting bills to auto insurance, med pay or to your health insurance.
3. It is your responsibility to obtain the following information from your insurance company: Name, Address, Phone, and Fax number, as well as the claim number, name and extension of the PIP adjuster NOT the adjuster for the damage to your car.
4. Your insurance company will send you a form called a "PIP Application". This form must be filled out by you as soon as it is received. Your insurance company will not pay your bills until this form is on file with them. Failure to send in your PIP application will cause the bills to become your responsibility.
5. If you have decided to utilize the help of an attorney you and your attorney will need to sign a Lien form, which is held on file at this office. The Lien is used should you have any outstanding bills that are awaiting settlement to be paid.
6. At some point during your care your insurance company will send you to another doctor for an evaluation. This is called an IME or an Independent Medical Examination. Please inform this office immediately once you are notified of an IME.
7. Keeping your scheduled appointments is imperative, not only for your recovery but also to ensure your claims will be paid. If an insurance company sees you missing appointments or changing your treatment plan without the recommendation of your doctors, they will assume that you are recovered and no longer need care.

"I understand the above information and agree to comply fully with the office policies of _____."

Signed_____ Date_____ Witness_____

Thank you for your time and cooperation.

PERSONAL INJURY INSURANCE INFORMATION

PATIENT NAME _____ DATE_____

ADDRESS_____

PHONE (H) _____ (W) _____

YOUR AUTO INSURANCE INFORMATION (Or OWNER OF VEHICLE)

NAME OF INSURED_____
(IF OTHER THAN YOURSELF)

NAME OF COMPANY_____ CLAIM # _____

ADDRESS_____

PHONE # _____ ADJUSTER _____ EXT # ____
HAVE YOU HAD OR BEEN SCHEDULED FOR AN INDEPENDENT MEDICAL EXAM (IME)? _____

OTHER DRIVER'S INFORMATION

NAME OF DRIVER _____

NAME OF COMPANY _____

ADDRESS _____ PHONE _____

NAME OF ATTORNEY_____PHONE_____

By law in Massachusetts we must bill your personal health carrier after $2,000.00 of personal injury benefits have been exhausted.
PERSONAL HEALTH INSURANCE COMPANY_____
Please provide our receptionist with a copy of your health insurance card.

I HEREBY AUTHORIZE _____ INSURANCE COMPANY TO PAY _____ DIRECTLY FOR MY HEALTH CARE COSTS. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO _____, AND I AGREE TO PAY ANY BALANCE OF PROFESSIONAL SERVICES OVER AND ABOVE THIS INSURANCE PAYMENT.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINANT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.

(Please read the above paragraph carefully before signing.)

_____ _____
SIGNATURE DATE

WITNESS _____