Dr. James Moore- Harpeth Chiropractic Center

To our valued patient,

We are truly sorry for the circumstances that have brought you to our office today. Our focus is providing you the best possible care so that you can recover as quickly as possible. To properly handle the billing of your case, it is essential you complete the forms attached and we have the following documents to proceed:

- Driver's License
- Your Auto Insurance Card and Declaration Page listing coverage
- At-Fault Party Insurance Information
- Attorney Information (if any)
- Accident/Incident Report

Injury Monkey, LLC will be handling your Personal Injury file. They are contracted by our office to ensure all documentation and necessary items are in place. They are also contracted to be patient advocates to ensure that you are educated and walked through this process. Your health is very important to us and we want to make sure you are taken care of.

PLEASE MAKE SURE YOU COMPLETELY ANSWER EVERY QUESTION, FILL IN EVERY BLANK AND BE SURE TO SIGN OR INITIAL EVERY SPACE THAT ITS REQUIRED. THESE FORMS ARE GOING TO BE ESSENTIAL WHEN IT COMES TIME TO SETTLE YOUR CASE OR IF YOU NEED TO OBTAIN AN ATTORNEY.

As you leave the office you will be given an information packet from Injury Monkey, LLC. Please contact their office within 24 hours of your first visit.

Thank you,

Dr. James Moore and Staff

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name   Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

2 INSURANCE INFORMATION

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date   Relationship to Patient

3 PHONE NUMBERS

Cell Phone (______) ____________ Home Phone (______) ____________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ____________ Relationship ____________

Home Phone (______) ____________ Work Phone (______) ____________

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ____________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______________________

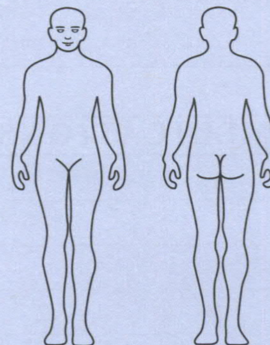
5 PATIENT CONDITION

Reason for Visit ______________________

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 your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

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

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6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ______________________________

Name and address of other doctor(s) who have treated you for your condition ______________________________

Date of Last: Physical Exam __________ Spinal X-Ray __________ Blood Test __________

Spinal Exam __________ Chest X-Ray __________ Urine Test __________

Dental X-Ray __________ MRI, CT-Scan, Bone Scan __________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other __________		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/Day __________
☐ Alcohol — Drinks/Week __________
☐ Coffee/Caffeine Drinks — Cups/Day __________
☐ High Stress Level — Reason __________

Are you pregnant? ☐ Yes ☐ No Due Date __________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS

Pharmacy Name __________

Pharmacy Phone (____) __________

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. *You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.*

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

______________________________	______________________________
Printed Name	Authorized Provider Representative
______________________________	______________________________
Signature	Date
______________________________	
Date	

Dr. James Moore - Harpeth Chiropractic Center

PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your auto insurance carrier on your behalf. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. Please notify us if you are using an attorney.

(initial) ________

MEDICAL PAYMENTS

"Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. Senate Bill 08-011, effective January 01, 2009, made Med-Pay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. If payment is made by this method, and you are not at fault, your insurance premiums may not increase. Med-Pay is primary for services rendered to personal injury patients when available. We require you to use your "Med-Pay" if it is available on your policy.

(initial) ________

THIRD PARTY

Tennessee is currently an "at-fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. We will accept a doctor's lien.

(initial) ________

HEALTH INSURANCE

We will ***NOT*** bill your personal health insurance for personal injury. We will bill the primary which will be Med-Pay and/or third party insurance. Workers' Compensation will be billed directly. We do ask to have the information on record for continued care after you have been released.

(initial) ________

RESPONSIBILITY

I, ______________________________ understand that I am primarily responsible for all medical bills and that in consideration for treatment from the motor vehicle accident, Dr. James Moore agrees not to demand payment at the time of service, and I agree to pay Dr. James Moore from the proceeds of any motor vehicle accident; and should I, my insurance company, third party insurance company or attorney fail to pay Dr. James Moore from the proceeds, I agree to pay all court costs, collection costs and attorney fees associated with the delinquent account.

(initial) ________

I have read and understand the personal injury/automobile accident financial policy of Harpeth Chiropractic Center. I understand that I am ultimately responsible for any services rendered to me by Harpeth Chiropractic Center. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

____
Patient Name

____
Patient or Guardian Signature

____
Date

Doctor's Lien

Dr. James Moore-Harpeth Chiropractic Center

Patient's Name:______________________________ Date of Birth: ____________________

I do hereby authorize Dr. James Moore to furnish to you with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct my insurance company, responsible party's insurance company and/or my attorney to pay directly to said doctor such sums as may be due and owing him for medical service rendered to me both by reason of settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a LIEN on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to my attorney, or directly to said doctor as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

(initial) ________

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, third-party settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

(initial) ________

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of debt.

(initial) ________

If my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient's Name: ______________________________

Patient or Guardian's Signature: ______________________________ Date:______________

____

Address City St Zip

The undersigned being attorney of record for the above patient do hereby agree to observe all the terms of the above and agrees to withhold such sums form any settlement, third-party settlement, judgment or verdict as may be necessary to adequately protect said doctor named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney Signature:______________________________ Date: __________

ASSIGNMENT OF INSURANCE BENEFITS AND PROCEEDS OF CLAIM

I am seeking treatment from Dr. James Moore ("the Doctor") for injuries I suffered in a vehicle accident. In consideration of receiving such treatment, I hereby assign to the Doctor the following monies to which I am or may become entitled.

1. **Insurance Benefits**. I have an automobile insurance policy issued by ______________________ insurance company. I hereby assign to the Doctor any benefits to which I am or may become entitled under that policy. The amount assigned to the Doctor shall be limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

2. **Proceeds of My Claim Against Another Party**. At this time it has not yet been determined which party caused the accident in which I was injured.

It may be determined at a later time, by a court through litigation or by settlement negotiations between the parties and/or their insurance company representatives, that another party caused the accident in which I was injured and that the other party is therefore responsible for paying damages to me in an amount sufficient to cover, in whole or in part, the medical expenses I have incurred as a result of the accident. If this determination is made through a settlement, the settlement agreement may provide that an amount of money shall be paid to me by the insurance company for the other party, even though the settlement agreement states that the payment shall be made without an admission of liability by the other party.

If the insurance company for the other party agrees to pay, or is ordered by a court to pay, a specified sum to me for bodily injuries I incurred in the accident, I hereby assign to the Doctor a portion of the monies I am entitled to receive from the other party's insurance company, limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

I understand that I am at this time making an assignment of the proceeds of a potential claim against the other party involved in the accident and that this assignment will be effective only after a determination, either by a court or by a settlement, that the other party's insurance company will pay a specified amount of money to me.

I understand that a copy of this Assignment must be provided to the insurance company for the other party before it will be binding on that company and that the Doctor must provide to that insurance company appropriate evidence of the services provided to me and the charges for those services.

By making this Assignment to the Doctor, I am directing ______________________________insurance company for the other party and/or my attorney ________________________________to pay the assigned amount directly to the Doctor.

Dr. James Moore- Harpeth Chiropractic Center
8122 Sawyer Brown Rd Ste 206
Nashville, TN 37221

I understand that if the insurance benefits and claim proceeds which are or become available to me are insufficient to cover the charges of the Doctor for the medical services provided to me, I am responsible for paying the balance of those charges.

I agree to notify the Doctor in writing at least thirty (30) days before changing this Assignment in any way.

______________________________ ______________________________

Witness Print Patient Name

____

Patient or Guardian Signature

Date: ______________________

Refer to judgment on Feb 5, 2015 by Supreme Court of Tennessee Action Chiropractic Clinic, LLC v. Prentice DelonHyler, ER AL.;Case No. M2013-01468-SC-R11-CV.

ACTIVITIES OF DAILY LIVING

Patient's Name:____ Date: ____________________________

Activity				
Carrying Groceries	__No Effect	__ Painful(can do)	__ Painful(limits)	__Unable to Perform
Sit to Stand	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Climbing Stairs	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Pet Care	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Driving	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Extended Computer Use	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Household Chores	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Lifting Children	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Reading/Concentration	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Dressing	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Shaving	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Sexual Activities	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Sleep	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Static Sitting	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Static Standing	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Yard Work	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Walking	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Washing/Bathing	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Sweeping/Vacuuming	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Dishes	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Laundry	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Garbage	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Bending	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Care for Family	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Kneeling	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Other:____________	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Other:____________	__No Effect	__ Painful (can do)	__ Painful (limits)	__Unable to Perform
Lifting (weight limit)	Circle one: 10lbs	20lbs 30lbs	40lbs	50lbs

Please mark **P** for "in the **Past**", **C** for "**Currently**" have and **N** for "**Never**"

__ Headache
__ Neck Pain
__ Jaw Pain,TMJ
__ Shoulder Pain
__ Upper Back Pain
__ Mid Back Pain
__ Low Back Pain
__ Hip Pain
__ Back Curvature
__ Scoliosis
__ Numb/Tingling arms, hands, fingers
__ Numb/Tingling legs, feet, toes

__ Pregnant(now)
__ Frequent Colds,Flu
__ Convulsions/Epilepsy
__ Tremors
__ Chest Pain
__ Pain w/Cough/Sneeze
__ Foot/Knee Problems
__ Sinus/Drainage Prob
__ Swollen/Painful Joints
__ Skin Problems

__ Dizziness
__ Loss of Balance
__ Fainting
__ Double Vision
__ Blurred Vision
__ Ringing in Ears
__ Hearing Loss
__ Depression
__ Irritable
__ Mood Changes
__ ADD/ADHD
__ Allergies

__ Prostate Problems
__ Impotence/Sexual Dysfun
__ Digestive Problems
__ Colon Trouble
__ Diarrhea/Constipation
__ Menopausal Problems
__ Menstrual Problems
__ PMS
__ Bed Wetting
__ Learning Disability
__ Eating Disorder
__ Trouble Sleeping

__ Ulcers
__ Heartburn
__ Heart Problem
__ High Blood Press.
__ Low Blood Press.
__ Asthma
__ Difficulty Breathing
__ Lung Problems
__ Kidney Trouble
__ Gall Bladder Trouble
__ Liver Trouble
__ Hepatitis(A,B,C)

8.4.17

Dr. James Moore
Harpeth Chiropractic Center
PERSONAL INJURY/AUTOMOBILE ACCIDENT CLAIM INFORMATION FORM

For Office Use Only:

- ☐ Copy of Driver's License
- ☐ ***Signed*** Dr's Lien
- ☐ ***Signed*** Financial Policy
- ☐ ***Signed*** AOB/Settlement
- ☐ Copy of Personal Auto Insurance
- ☐ Copy of Per. Auto Declaration Page
- ☐ At-Fault Auto Info
- ☐ Attorney Info (if any)
- ☐ Accident Report
- ☐ Injury Monkey,LLC Business Card to Patient
- ☐ Injury Monkey,LLC Intro Letter to Patient

Verified by:________________ Date________

Today's Date ____________________

Patient Name:____

Guardian Name: ____

YOUR Auto Insurance Information

Name of Insurance Company: ____

Telephone #:____

Name on Policy:____

Policy #:____

Claim#:____

Claims Representative Name:____

Claims Representative Phone #:____

Do you have Medical Payments Benefits on your policy?

- ☐ Yes, Amount: __________
- ☐ No
- ☐ I don't know

Third Party/At Fault Driver Insurance Information

Third Party/Driver's Name:____

Name of Insurance Company:____

Telephone #:____

Name on Policy:____

Policy #:____

Claim#:____

Claims Representative Name:____

Claims Representative Phone #:____

Attorney (it is not always necessary to have an attorney for PI claims)

Name of Law Firm:____

Name of Attorney:____

Phone #:____

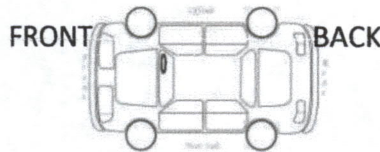
Patient / Guardian Signature:____

8.4.17

Dr. James Moore
Harpeth Chiropractic Center
ACCIDENT HISTORY QUESTIONNAIRE

Patient Name____Date__________

1. Date of Accident:____________________________________2. Time:______________________AM/PM
3. Driver of Car:____
4. Where were you seated?____
5. Who owns the car?____
6. Year & model of your car:____
   Year & model of other car:____
7. What was the approximate damage done to your car? $_________________________________
8. Visibility at time of accident ☐Poor ☐Fair ☐Good ☐Other:____________________________
9. Road conditions at the time of accident:☐Icy ☐Rainy ☐Wet ☐Clear ☐Dark
   ☐ Other(describe)____
10. Where was your car struck?

FRONT  BACK

In your own words, please describe accident:____
____
____
____
____

11. Type of Accident:☐Head-on collision ☐Broad-side collision ☐Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of thecar:____
____
13. Did you see the accident coming? ☐Yes ☐No
14. Did you brace for impact?☐Yes ☐No
15. Were seat belts worn?☐Yes ☐No
16. Where shoulder harnesses worn?☐Yes ☐No
17. Does your car have headrests?☐Yes ☐No If yes, what was the position of those headrests compared to your head before the accident?
   - ☐ Top of headrest even with bottom of head
   - ☐ Top of headrest even with top of head
   - ☐ Top of headrest even with middle of neck
18. Was your car braking?☐Yes ☐No
19. Was your car moving at the time of the accident? ☐Yes ☐No
20. If yes, how fast would you estimate you were going?_______________mph
21. How fast would you estimate the other car was going?_____________mph
22. Head/body position at the time of impact

☐ Head turned left/right	☐Body straight in sitting position
☐ Head looking back	☐Body rotated right/left
☐ Head straight forward	☐Other:_______________________________

23. As a result of the accident you were:☐Rendered unconscious ☐In shock
   ☐ Dazed, circumstances vague ☐Other:____

24. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
25. Were you wearing a hat or glasses? ☐ Yes ☐ No
26. Could you move all parts of your body normally or as you could before the accident? ☐ Yes ☐ No
27. If no, what parts couldn't you move and why? ____________________
28. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
29. If no, why not? ____________________
30. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? ____________________
31. Did you get any bruises? ☐ Yes ☐ No If yes, where? ____________________
32. Please describe how you felt:
    Immediately after the accident: ____________________
    Later that day: ____________________
    The next day: ____________________
33. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid backpain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other ____________	

34. Occupation: ____________________
35. Employer: ____________________
36. Have you missed time from work? ☐ Yes ☐ No
37. If yes, full time off work: ____________ to ____________
38. If yes, part time off work: ____________ to ____________
39. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
    ☐ If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone Else Drove Me
    ☐ Drove Own Car ☐ Other: ____________
40. Doctor #1:Name: ____________________
41. First visit date: ____________________
42. Were you examined? ☐ Yes ☐ No
43. Were X-rays taken? ☐ Yes ☐ No
44. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
45. If yes, what kind of treatment did you receive? ____________________
46. What benefits did you receive from the treatment? ____________________
47. Date of last treatment? ____________________
48. Doctor #2:Name: ____________________
49. First visit date: ____________________
50. Were you examined? ☐ Yes ☐ No
51. Were X-rays taken? ☐ Yes ☐ No
52. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
53. If yes, what kind of treatment did you receive? ____________________

____________________ Patient / Guardian Signature

____________ Date