VEHICLE ACCIDENT INFORMATION

Patient Information

Patient Name: _____ Date: _____
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

How many people were in the accident? _____

Location

Road/Street name:_____
City/State:_____
Nearest intersection:_____
Driving conditions:❒ Dry ❒ Wet ❒ Icy ❒Other
Which direction were you headed?_____
What speed were you traveling? _____

Specifics

Did your car impact another vehicle?
❒ Yes ❒ No
Did your car impact a structure?
❒ Yes ❒ No
If yes, explain: _____
_____
Was the impact from the:
❒ Front ❒ Rear ❒ Left ❒ Right
At the time of impact were you:
❒Looking straight ahead ❒ Looking up
❒Looking to the left ❒Looking down
❒Looking to the right

Your Vehicle

Make and Model of your vehicle:_____
Were you wearing a seatbelt? ❒ Yes ❒ No
If yes, what type: ❒ Lap ❒ Shoulder
Did the vehicle have airbags? ❒ Yes ❒ No
Did they inflate properly? ❒ Yes ❒ No
Did your vehicle have a headrest? ❒ Yes ❒ No
If yes, what was the position of the headrest?
❒ Low ❒ Midposition ❒ High

Other Vehicle

Make and model of the other vehicle:_____
Which direction was the other vehicle headed?
_____
Speed of the other vehicle: _____

Police Information

Did the police come? ❒ Yes ❒ No
Were there any witnesses?❒ Yes❒No
Is there a police report? ❒ Yes ❒ No

Turlock Family Chiropractic
2360 W. Monte Vista Ave. Turlock, CA 95382
Phone: (209) 668-3841

Patient Condition

Were you unconscious immediately after the accident? ❒ Yes ❒ No
If yes, for how long? _____
Please describe how you felt immediately after the accident: _____
_____
_____
_____

Treatment

Did you go to the hospital? ❒ Yes ❒ No
If yes, when did you go? ❒ Immediately ❒ Next Day ❒ 2 days or more after the accident
How did you get to the hospital? ❒Ambulance ❒ Private vehicle
Name of the hospital: _____
Diagnosis: _____
_____
Treatment received: _____
_____
X-Rays taken: _____

Symptoms / Injuries

Have you been to work since your injury? ❒ Yes ❒ No How many days missed? _____
Prior to the injury were you able to work on an equal basis with others? ❒ Yes ❒ No
Check the boxes if you have had any of these symptoms since your injury:

❒ Arm/Shoulder Pain	❒ Feet/Toe Numbness	❒ Neck Pain
❒ Back Pain	❒ Hand/Finger Numbness	❒ Neck Stiffness
❒ Back Stiffness	❒ Headaches	❒ Shortness of Breath
❒ Chest Pain	❒ Irritability	❒ Sleep Difficulty
❒ Dizziness	❒ Jaw Problems	❒ Stomach Upset
❒ Ear Buzzing	❒ Leg Pain	❒ Tension
❒ Ear Ringing	❒ Memory Loss	❒ Vision Blurred
❒ Fatigue	❒ Nausea	

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Unknown
Type of pain:

❒ Sharp	❒ Dull	❒ Throbbing	❒ Numbness
❒ Aching	❒ Shooting	❒ Burning	❒ Tingling
❒ Cramps	❒ Stiffness	❒ Swelling	❒ Other _____

How often do you have this pain? _____
Does it interfere with your: ❒ Work ❒ Sleep ❒ Daily Routine ❒ Recreation
Activities or movements that are painful to perform:
❒ Sitting ❒ Bending ❒ Standing ❒ Walking ❒ Lying down

Pain Scale 0-10

Patient Name: _____

Reported Pain Intensity

0	1	2	3	4	5	6	7	8	9	10
No Pain					**Moderate Pain**					**Worst Pain**

CONCUSSION QUESTIONNAIRE

Patient Name: _____ Date: _____

Please check any of the following boxes that correspond to any symptom(s) or other problems that you have had or observed recently since your injury.

YES	SYMPTOM DESCRIPTION
❒	Headaches
❒	Loss of coordination
❒	Reduced drive or motivation
❒	Poor memory
❒	Difficulty finishing tasks
❒	Sleep disorders
❒	Abnormal levels of anxiety
❒	Reduced tolerance to alcohol
❒	More assertive
❒	Forgetful
❒	Anger outburst
❒	Depression
❒	Fatigue
❒	Absence of ability to anticipate
❒	Inflexibility
❒	Impaired sexual functions
❒	Language difficulty
❒	Impaired judgement
❒	Need day timer to remember home and/or work activities
❒	Blurry vision
❒	Loss of balance
❒	Difficulty handling multiple tasks
❒	Dizziness/lightheadedness
❒	Irritability
❒	Personality change
❒	Head tremors
❒	Ringing in the ears
❒	Less diplomatic than normal
❒	Mood swings
❒	Reduced attention span
❒	Blackouts
❒	Indifference to other people
❒	More shallow relationships
❒	Difficulty with problem solving
❒	Less mental stamina
❒	Performance inconsistencies
❒	Verbal learning issues
❒	Slower reaction times

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FINANCIAL AGREEMENT OF PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policies of this office, I would like to explain how your medical bills will be handled.

Party Responsibility
If you were involved in an auto accident and are the owner of the vehicle then we will bill the medical insurance portion of your own automobile insurance policy.
If you were the passenger in someone else's car then we will bill the driver's auto insurance company.
If you were a passenger in a vehicle which wasn't insured, but your own car which has medical coverage on the insurance policy, then the insurance company which carries YOUR policy will be responsible to pay your medical bills.

Insurance Rates
It is important to remember that when a medical claim is submitted to the "medical payments" portion of your insurance policy, your standing with the insurance company will not be affected, and your rates will not normally be increased, unless the accident is determined to be your fault.

Billing Other Insurance Policies
It is also to your advantage for our office to bill your own health insurance policy and/or automobile medical policy for your medical bills, providing your policy doesn't state otherwise. Any money received above and beyond your total bill in this office will be refunded to you.

Responsibility of Payment
As courtesy to you, we will gladly submit your medical bills to your insurance company and/or your attorney, however all services rendered by this office will be charged directly to you, and ultimately you will be personally responsible for payment of these bills regardless of any settlement you may or may not receive.

Once again, we welcome you to this office. We hope that this has answered any questions that you might have about our personal injury financial arrangements. If, at any time you have further questions about your care, please don't hesitate to ask.

I have read and agree with the above.

Patient's Signature: _____ Staff Initials:_____ Date: _____

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NOTICE OF DOCTOR'S LIEN

Patient's Name:_____ Date of Accident: _____

I do hereby authorize Greg T. Jones, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of settlement, judgement or verdict which may be paid to you, my attorney or myself 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 honors 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 services rendered to 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, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

Patient's Signature:_____ Date:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect said doctor above-named.

Attorney Signature:_____ Date:_____

PLEASE DATE, SIGN AND RETURN ONE COPY TO DOCTOR'S OFFICE
ALSO KEEP ONE COPY FOR YOUR RECORDS

Personal Information

Name:_____Cell Phone#:_____
Address:_____ City:_____
State: _____ Zip Code: _____
SSN: _____ Date of Birth:_____
Age: _____ Height: _____ Weight: _____
Male ❒ Female ❒ Single ❒ Married ❒ Divorced Spouse/Parent Name:_____
Employer: _____ Occupation: _____
Address:_____ City:_____
State: _____ Zip Code: _____
Work phone:_____