



AUTO INJURY FORM

Today's Date _____

Patient's Name: _____

Date of Accident: _____

State of Accident: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | |

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver
 Passenger ----- Location----- Left Middle Right
 Other _____ Front Passenger Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx ____MPH
 Moving Slowly

Why Vehicle was slowed or stopped:

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection

Collision Type:

- Driver Side Impact Head On Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- Totally unaware that the accident was impending
- Aware that the accident was impending
- Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- Seat belt
- Shoulder harness
- No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by impact

Was the air bag deployed?

- Car not equipped with air bag
- Air bag deployed
- Air bag not deployed

What position was YOUR headrest in?

- High position
- Middle position
- Low position

Position of YOUR head at time of impact?

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Position of Your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Right Arm

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Torso

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest | <input type="checkbox"/> Console |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Gear shift |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat |
| <input type="checkbox"/> Left door | <input type="checkbox"/> Backseat |

Left Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

Next day discomfort...?

- increased
- decreased
- same

Did your major complaints exist before the accident?

- Yes
- No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

At the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Patient's Name _____

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Have you lost any days of work? () Yes () No If Yes, _____ through _____
Have your work duties been effected in any way? () Yes () No If yes, how? _____

INSURANCE/ATTORNEY INFORMATION

Your insurance _____ Your medical claims adjuster _____

Claims adjuster's phone# _____ ext; _____ Fax# _____

Claim# _____

Other party's insurance _____ Your medical claims adjuster _____

Claims adjuster's phone# _____ ext. _____ Fax# _____

Claim# _____

Have you retained an attorney? () Yes () No If so, his/her contact information: _____

Patient's Signature: _____ Date _____



FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.
5. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Patient's signature (or guardian if patient is a minor) Date

Witness



CREDIT GUARANTEE AUTO INSURANCE ASSIGNMENT PERSONAL BALANCES

Patient Name: _____

Claim#: _____

Date of Injury: _____

Insurance Information: _____

INSURANCE ASSIGNMENT

Our Auto 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 insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Your complete automobile insurance information
Your family health insurance plan information

FILING PROCEDURE

We will periodically submit claims on your behalf to both your automobile and health insurance carriers. Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: AMEX VISA MC DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

I agree to the above terms and authorize/request the insurance company to pay Rock Solid Chiropractic directly for my treatment. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by my physician, I will be charged the amount outstanding on my account.

Signature _____

Date _____

DATE