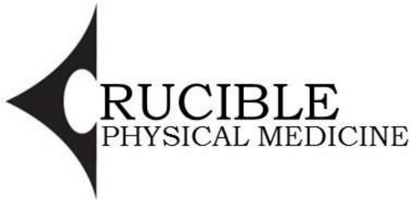


AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:___________________________________ Today's Date:_________________

Patient's Address:____

Patient's DOB:__________________ SSN:_________________________ Date of Accident:___________________

Phone Number:____________________________ Email Address:____________________________________

Your Automobile Insurance Company:

Name of Company____Phone_____________________________

Address____

Claim #____________________________ Policy#_________________________________

Third Party Insurance Company

Name of Company____Phone_____________________________

Address____

Claim #_____________________________ Policy#_____________________________

Adjusters Name_________________________________ Direct Contact Number________________________

Advising Attorney Information:

Name of Attorney____Phone___________________________

Address____

Assignment of Benefits by a Patient to a Physician:

I hereby assign to my physician all benefits for such services to which I am entitled under my Personal Injury Protection and/or Medical Payments coverage, and request my insurance company to pay any such benefits directly to my physician upon submission of any claim.

Signed____Date_____________________________

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
❑Bus ❑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

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

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

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

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

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

Left Leg

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

Right Leg

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑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	❑Weak
❑Dazed	❑Nervous
❑Disoriented	❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

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

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

Next day discomfort...?

❑increased ❑decreased ❑same

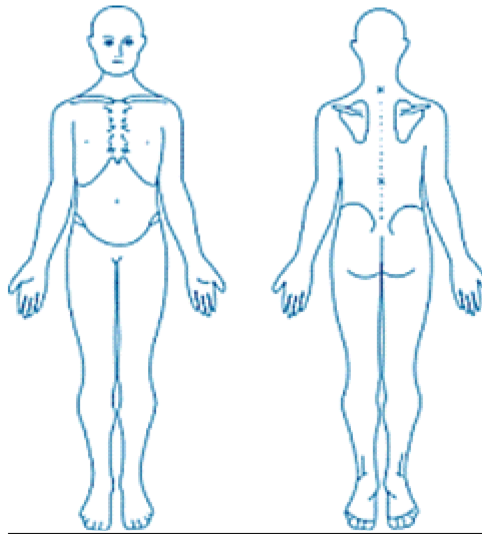
Did your major complaints exist before the accident?

❑Yes ❑ No

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

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back						
❑Pelvis						

Please mark your areas of pain on the figure below.



CRUCIBLE PHYSICAL MEDICINE HEALTH INSURANCE AFFIDAVIT

In order for this office to process your claim efficiently, it is necessary to obtain the following information regarding other health benefits available to you.

Any medical expenses in excess of $2,500 will not be paid under your Auto policy if those expenses will be compensated, paid, or indemnified by an outside insurance carrier. Bills submitted to your Auto insurance carrier over the $2,500 limit must be accompanied by an explanation of benefits from your health carrier or a copy of this Affidavit.

I hereby certify that I have the following health insurance benefits available to me:

Health Insurance Co: ____

Policy Number: ____________________________________

I hereby certify this I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

____ ____________________

Signature **Date**

Patient: _______________________________________ DOB: __________________

MVA Date: _______________

Patient: ____

Carrier 1: ____

Carrier 2: ____

Attorney: ____

RE: PATIENT RECORDS, IME REQUEST, PIP Application and DOCTOR'S LIEN

I do hereby authorize Crucible Physical Medicine to furnish my Attorney/Insurance carrier, with a full report of my case history, examination, diagnosis, treatment, and prognosis in regard to my accident/illness which occurred/began on ________________.

I also authorize and request my Attorney/Insurance Company to send any IME report, PIP Application or request for me to attend an IME to Crucible Physical Medicine.

I hereby give a lien to said Doctor on any settlement, claim judgment, or verdict as a result of said accident/illness, and authorize and direct you, my Attorney/Insurance carrier, to pay directly to said Doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said Doctor adequately.

I understand that I am directly and fully responsible to said Doctors or Nurse Practitioner for all 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. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated:____________________Signature: _________________________________

The undersigned, being Attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named Doctor.

Dated:______________________Authorized signature: ______________________

INFORMED CONSENT

When a patient seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals. The practice of chiropractic in this office consists of analysis and adjustment of the spine for the purpose of locating and correcting vertebral subluxations. (Spinal misalignments causing nerve interference). We also strive to educate and encourage our patients/practice members to become aware of and responsible to their wellbeing.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

Physicians, chiropractors, osteopaths and physiotherapists using manual manipulation are required to advise their patients that there have been rare incidents of injury to the vertebral artery during the course of treatment. There have caused strokes or stroke-like occurrences which are usually of a temporary nature. The chances of this happening are approximately 1 in 3 million treatments. There have also been rare incidents of rib bruising or swelling of aggravation of symptoms. Appropriate tests will be performed on you to minimize your risks.

It is important that you understand that chiropractic care involves a "hands on" approach. During the delivery of a chiropractic adjustment or diagnostic procedure, there may be physical contact made in possibly sensitive areas. By signing below you are acknowledging that you have been informed of and consent to the type of care you will receive and that you have been made aware of any risks inherent in that care. You also acknowledge that you have been made aware of other treatment options. If a change in approach, additional testing, and referrals to other providers or a need to apply care requiring a different touch is required it will be discussed with you prior to it being administered. If at any time you are in any way uncomfortable with any aspect of the care that you are receiving, please do not hesitate to let us know.

Our practice is based on the simple truth that if we satisfy and delight our patients, they will get well faster and be more likely to tell others about their chiropractic experience. Since chiropractic results vary, we can' guarantee results, but we can promise your satisfaction. Within 3 days of beginning care, if you are not completely happy with your decision to begin chiropractic care in this office, we will happily refund the money you've paid us.

I/We understand and consent to care at Crucible Physical Medicine for myself/my family, as outlined in this "Informed Consent".

Name (print): ____________________________

Signed: ________________________________

Date: _____________

Nurse Practitioner Consent

Crucible Physical Medicine would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners to assist us in a team approach to deliver our high quality of medical care.

A Nurse Practitioner (NP) is a mid-level practitioner who has received advanced education and training in the provision of health care. They can however, diagnose, treat, and monitor routine and complex pain disorders. If you are seen by a Nurse Practitioner, your doctor will review your care with the NP as part of the care plan.

I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a NP.

I hereby consent to the services of a Nurse Practitioner for my healthcare needs.

Name (print):____

Signature:____

Date:___________________