AUTOMOMIBLE ACCIDENT QUESTIONNAIRE
FOR SCHIERLING CHIROPRACTIC, LLC

PLEASE BE AS SPECIFIC AS POSSIBLE!

NAME: ____ Date of Accident_______________
Where did the accident occur? ____
What time of day did the accident occur? __________

Describe the accident in your own words: Be as specific as possible!

Did your vehicle strike another vehicle Yes No
Make, Model, and Year of your vehicle: ____
Make, Model, and Year of other vehicle: ____
What were road conditions? DRY WET ICY FOGGY GRAVEL OTHER________________
Were you aware the accident was going to happen or were you caught by surprise? AWARE SUPRISE
How much property damage did your vehicle sustain? Minimal Moderate Extensive Totaled $$$_________
How much property damage did the other vehicle sustain? Minimal Moderate Extensive Totaled
At the time of impact, was your vehicle STOPPED MOVING If moving, estimate how fast (mph):________
At time of impact, were you looking STRAIGHT AHEAD RIGHT LEFT
Did an airbag deploy? Yes No Please Describe ___________________________________
Was your vehicle an automatic or a standard transmission? AUTOMATIC STANDARD(you must shift gears)
Were you wearing a seat belt? Yes No Was your headrest? UP DOWN UNKNOWN
Did your vehicle flip over or roll over? Yes No
Were you hit from the: FRONT LEFT SIDE RIGHT SIDE REAR ENDED
Was there a second collision after the first collision? Yes No If yes, please describe_____________
Were you thrown out of your seat? Yes No _____________
Were you thrown out of the vehicle? Yes No _____________
____

What was your position in the vehicle?
Driver: If Driver were your hands on the steering wheel? Left hand Right hand Both
Passenger: If passenger, were you sitting in Front Right Rear Left Rear
Did you brace for impact? Yes No … I braced with my hands I braced with my feet
Which way were you facing or looking at the time of impact… straight ahead Left Right

Did you strike anything in the vehicle at the time of impact? Yes No
If yes, specify what part of your body struck what: For example: if your chest and shoulder hit the steering wheel, simply check “steering wheel” and write chest and shoulder next to it.

Steering Wheel ______________________ Dashboard _______________________
Windshield ________________________ Roof___________________________
Left Side Door ______________________ Right Side Door___________________
Left Side Window. ___________________ Right Window ____________________
Other ____
Did the seat back bend / break down flat? Yes No

Did you lose consciousness? Yes No If yes, for how long?_________________
Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious
nervous nauseous upset weak Other ___________________________________
Have you had any of these symptoms since then? Yes No If yes, please describe:___________
Have you been heat intolerant since the accident? Yes No
Has the accident affected your moods? Yes No If yes, please Describe___________________

Did you go to hospital Yes No Were you admitted to the hospital? Yes No if yes how long was your stay? ____________________

If you went to hospital, when? At time of accident Next day
How did you get to hospital? Ambulance Police Car Private Transportation
Name of Hospital:____
Attended by Dr. ____

… what treatment was given?

☐none ☐placed in a cervical collar ☐x-rayed ☐ given stitches ☐Bandaged
☐ given pain or or other medication(s) ☐given instructions regarding concussions
☐given instructions regarding sprains and strains ☐ Physical Therapy
☐instructed to call a Orthopedic Surgeon ☐instructed to call a private physician
☐referred to this office for treatment ☐ Other ______________________________
____

Have you seen any other doctor(s) as a result of this accident? Yes No
Doctor's name(s)

Are you still seeing a doctor as a result of this accident? Yes No If "yes" how often? __________

CHIEF Complaints or Symptoms:

☐**Neck pain** check off the areas that the pain runs into from the neck ☐headache ☐Migraine Headache ☐upper back pain	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night
☐nightmares ☐difficulty sleeping at night

☐**Low Back Pain** select the areas of radiating pain, if any...	☐None ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness and/or Tingling:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints: Be as specific as possible!

Have You lost any time from work due to your injuries? Yes No

If yes please give dates: ____

Type of employment: ____

Have you had previous injuries or accidents? Yes No

Description of previous Accident:

____

Description of injuries due to previous accident:

____

Was/Is there any residual pain from the previous injury? Yes No

Were you having pain prior to your most recent accident? Yes No

INSURANCE COVERAGE INFORMATION

Did the Auto Accident occur while working on the job? Yes No

If yes, has the accident been filed as Worker's Compensation? Yes No Employer: ________________

Were the police notified? Yes No Was a police report made? Yes No

Do you have a copy of the police report? Yes No **IF YES, PLEASE PROVIDE US WITH A COPY

Who was cited as being responsible for the accident? ____________________________________

Was Insurance Information exchanged? Yes No **IF YES, PLEASE PROVIDE US WITH A COPY

LIABILITY INFORMATION:

Has the accident been reported to your insurance company? Yes No

Insurance Carrier: ______________________ Phone: ___________________ Name of Adjuster: ____________

Name of Insured: _____________________ Policy #: ________________________ Claim #: _______________

Has insurance paid for your vehicle damage? Yes No

MEDPAY INFORMATION:

(Be aware that filing a MedPay claim does NOT raise your insurance rates)

(In order to file MedPay, we must have a copy of your Accident Report)

Has the accident been reported to your Auto Insurance Company? Yes No

Do you have medical payments coverage (MedPay) on your Auto Insurance plan? Yes No
Have you received any benefits from your Auto Insurance Company yet? Yes No
Insurance Carrier: ________________________ Phone: ________________ Name of Adjuster: ____________
Name of Insured: _________________________Policy #: _________________ Claim #: __________________

ATTORNEY REPRESENTATION:
Have you retained an Attorney? Yes No ATTORNEY NAME: ____________________________
Phone number: ______________

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, the patient -- not between my insurance company and Schierling Chiropractic, LLC. I understand that interest will be charged at the annual rate of18%, and appear on all accounts over 90 days old. ***I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Schierling Chiropractic, LLC for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.*** Furthermore, I understand that in the event this account is sent to collections, a 53% collection fee will be added to the bill.

I authorize Schierling Chiropractic, LLC to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: X___________________________ Date: __________