Inner Source Family Chiropractic
Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Date of Birth _____
Home Phone _____ Cell Phone _____
Address_____
City_____State_____
Occupation_____ Who referred you to our office?_____
Social Sec. # _____
Your Insurance company _____Policy No. _____Claim No._____
Health Insurance Company_____ ID#_____ Owner of Ins/DOB_____
Location of Accident_____
Date and Time of Accident _____
Make and Model of Your Car _____

Accident Details:

Please explain in detail how your accident happened_____
_____
_____
_____
_____
_____

You were struck from • Behind • Front • Left side • Right side
You were • Driver • Passenger • Front seat • Back seat • Using seat belts • Other protective devices
How were you sitting before the impact? Head was: Straight • Looking up / down • Looking Left / Right
Body was: Straight • Rotated Left / Right
Did you brace for the impact? • Yes • No
Was YOUR car • Stopped • Braking • Moving without brakes in use
Approximate speed just before impact? _____
Was THEIR car • Stopped • Braking • Moving without brakes in use • Unknown • There was no other vehicle involved
Approximate speed just before impact? _____
Did your airbags inflate? • Yes • No

Your Injuries:

Were you knocked unconscious? •Yes •No If Yes, for how long?_____
Where did you feel pain immediately after the accident?_____
Where did you feel pain the next 24-48 hours after the accident? _____
Were you able to move all parts of your body after the accident? • Yes • No
If no, which part(s) and why? _____
Were you able to get out of your car and walk without assistance? • Yes • No
Was there any • Scrapes • Cuts • Burns • Bruising • Bleeding • None Location on body_____

Check symptoms you have noticed since the accident:

__Headache	__Dizziness	__Depression	__Fatigue
__Stomach Upset	__Light Sensitivity	__Buzzing in Ears	__Diarrhea
__Neck Pain	__Head seems too Heavy	__Loss of Memory	__Feet Cold
__Neck Stiff	__Pins and Needles in Arms	__Ears Ringing	__Hands Cold
__Fainting	__Sleeping Problems	__Loss of Balance	__Back Pain
__Face Flushed	__Pins and Needles in Legs	__Constipation	__Tension
__Nervousness	__Numbness in Fingers	__Loss of Smell	__Fever
__Irritability	__Numbness in Toes	__Loss of Taste	__Chest Pain
__Cold Sweats	__Shortness of Breath	Other_____	Other _____

Your Injuries (continued):
What is your Chief Complaint Injury of your car accident?_____
Secondary Complaint? _____
Have you ever had any complaints in the involved area(s) before? • Yes• No
If so, what were the complaints?_____
Before the injury, were you capable of working on an equal basis with others your age? • Yes • No
Are your work activities restricted as a result of this accident? • Yes • No
Have you lost time from work as a result of this accident? • Yes• No
If yes, please complete: Last day worked_____
Place & type of employment_____
Since this injury are your symptoms • improving? • getting worse? • the same?

Any other significant symptoms noticed since accident?_____
_____
_____

Treatment Provided:
What treatment was given at time and location of accident?_____
Did you go to the hospital immediately following the accident? • Yes • No Where?_____
Were X-Rays taken? • Yes • No MRI? • Yes • No CT Scan? • Yes • No Other Tests?_____
What was the diagnosis?_____
What treatment/medication was given?_____

Was any other doctor consulted after your accident? • Yes • No When?_____
If so, what was the doctor's name?_____ • D.C., • M.D., • D.O., • D.D.S.
What was the diagnosis?_____
What treatment/medication was given?_____

Thank You

Patient Signature_____ **Date**_____

Inner Source Family Chiropractic

2 Enon Street North Beverly, Ma 01915

T 978-810-6799 **E** drcourtney@innersourcewellness.com **W** innersourcewellness.com

HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c90, Section 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below. Thank you very much.

1) Are you eligible for coverage under any **Health Insurance Plan**? ( ) Yes ( ) No

A. If yes, please answer and/or provide a copy of your insurance card

Name of Plan:_____
Address for Claims: _____
Telephone: _____
Group Plan #: _____
Policy #: _____
Subscriber Name:_____

If subscriber is different from you, please provide:

Relationship to You: _____
Date of Birth: _____
Address of Member: _____
Phone Number: _____

2) If No, are you eligible for health coverage under and **government program**?

( ) Yes ( ) No

Applicant's Signature: _____

Date: _____

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Authorization to Release Medical Records

I hereby authorize Inner Source Family Chiropractic to release information concerning my diagnosis and treatment to my insurance company and/or attorney (if applicable) for the purpose of processing claims for the benefits for this visit or other related visits. I am not giving permission for any disclosure of this information other than specified above.

_____
Signature (patient, parent, or guardian)

_____
Print name of signer

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Authorization for Receiving Medical Information

Patients Name: _____

Date: _____

Date of Exam: _____

Date of Birth: _____

SS#: _____

To Whom it May Concern:

I hereby authorize any physician, hospital, and all medical attendants to furnish complete medical information, reports, x-rays results to Inner Source Family Chiropractic.

Your full cooperation with my Chiropractor is requested.

_____
Signature (patient, parent, or guardian)