Hayes Sports Chiropractic

AUTO ACCIDENT INFORMATION

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ ☐am ☐pm

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Number of people in the accident vehicle _____ Did the police come to the site? ☐yes ☐no

If a traffic citation was issued, to whom was it issued? _____

Were there any witnesses? ☐yes ☐no Were you wearing a seatbelt? ☐yes ☐no

In relation to the base of your skull, where was the headrest? ☐above ☐below ☐at the base of the skull

Was the vehicle equipped with airbags? ☐yes ☐no If yes, did they inflate? ☐yes ☐no

Did any part of your body strike anything or anyone in the vehicle? ☐yes ☐no

If yes, please describe: _____

What did your vehicle impact? ☐Another vehicle ☐Other

If other, please describe: _____

Name of the location / street on which you were traveling: _____

What direction were you heading? ☐N ☐S ☐E ☐W What was the approximate speed of your vehicle? _____

The impact to your vehicle came from the: ☐Front ☐Rear ☐Right Side ☐Left Side Other _____

During the impact, were you facing: ☐Forward ☐Right ☐Left ☐Backwards

Were you: ☐Aware or ☐Surprised by the impact?

If the accident involved another vehicle, what direction was the other vehicle traveling? ☐N ☐S ☐E ☐W

Approximate speed of the other vehicle: _____

Please describe the accident in your own words:

Were you rendered unconscious? ☐yes ☐no

Were you treated for injuries at the scene of the accident? ☐yes ☐no

How did you feel immediately after the accident? _____

Where did you go immediately after the accident? ☐Hospital ☐Home ☐MD ☐This office ☐Resumed activities

Have you been able to work since this injury? ☐yes ☐no Are your daily activities affected by this injury? ☐yes ☐no

Indicate the symptoms that are a result of this accident: ☐Dizziness ☐Difficulty sleeping ☐Nausea ☐Jaw problems ☐Memory loss ☐Irritability ☐Arm/shoulder pain ☐Back pain ☐Neck pain ☐Headache(s) ☐Fatigue ☐Tension ☐Numbness in hands/fingers ☐Blurred vision ☐Numbness in feet ☐Numbness in toes ☐Stomach upset ☐Other - please describe: _____

Is your condition getting worse? ☐yes ☐no ☐constant ☐comes and goes

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AUTO ACCIDENT INFORMATION

Accident Insurance Information

Your Automobille Insurance

Name of Insurance Company _____ Claim# _____

Adjusters Name _____ Phone _____

Address _____

Other Parties Insurance

Name of Insurance Company _____ Claim# _____

Adjusters Name _____ Phone _____

Address _____

Attorney Information

Attorney Name _____ Phone _____

Address _____ Fax _____

Accident Information

Did your accident occur while at work? ☐yes ☐no

Where you the driver or passenger? _____

Description of accident:

Approx. speed of your vehicle: _____ Approx. speed of the car that hit you: _____

Was a police report taken? ☐yes ☐no Who was considered "at fault"? _____

Were you injured? ☐yes ☐no Were you unconscious? ☐yes ☐no

Fractures: _____ Cuts: _____

Abrasions: _____ Bruises: _____

Were you taken to the hospital? ☐yes ☐no

Have you had any other personal injury or accident?

☐Past year ☐Past 5 years ☐Over 5 years ☐I have never been in an accident before

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FINANCIAL AGREEMENT PERSONAL INJURY

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

Party Responsibility
If you were involved in an auto accident in your vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your automobile insurance policy to cover the treatment charges incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and you own a car that has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
3rd Party: If another vehicle has caused the accident, we will first bill your automobile Med Pay or PIP policy for coverage before submitting a claim to the insurance carrier of the party at fault. If we rely solely on a 3 party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement.
By signing this form, you are agreeing to pay your balance in full within 3 days of receiving your settlement.

_____(Patient's Initials)

It is also to your advantage for our office to bill your health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

Attorney Liens
If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your lawsuit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment
As a courtesy to you, we will gladly submit your charges to your insurance companyies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____
Patient's Signature **Date**

_____ _____
Patient's Name Printed **Witness' Signature**

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PAIN DISABILITY QUESTIONNAIRE (PDQ)

Name: _____

Date of Accident: _____

This survey asks you for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by marking a box along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

Does your pain interfere with your normal work inside and outside the home?

☐ ☐ ☐ ☐ ☐

Work normally — Unable to work at all

Does your pain interfere with personal care (such as washing, dressing, etc.)?

☐ ☐ ☐ ☐ ☐

Take care of myself completely — Need help w/ all my personal care

Does your pain interfere with your traveling?

☐ ☐ ☐ ☐ ☐

Travel anywhere I like — Only travel to see doctor

Does your pain affect your ability to sit or stand?

☐ ☐ ☐ ☐ ☐

No problems — Cannot sit/stand at all

Does your pain affect your ability to lift overhead, grasp objects, or reach things?

☐ ☐ ☐ ☐ ☐

No problems — Cannot do at all

Does your pain affect your ability to lift objects off the floor, bend stoop, or squat

☐ ☐ ☐ ☐ ☐

No problems — Cannot do at all

Does your pain affect your ability to walk or run?

☐ ☐ ☐ ☐ ☐

No problems — Cannot run/walk at all

Has your income declined since your pain began?

☐ ☐ ☐ ☐ ☐

No decline — Lost all income

Do you have to take pain medication everyday to control your pain?

☐ ☐ ☐ ☐ ☐

No medication needed — On pain medication throughout the day

Does your pain force you to see doctors much more often than before your pain began?

☐ ☐ ☐ ☐ ☐

Never see doctors — See doctors weekly

Does your pain interfere with your ability to see the people who are important to you as much as you would like?

☐ ☐ ☐ ☐ ☐

No problem — Never see them

Does your pain interfere with recreational activities and hobbies that are important to you?

☐ ☐ ☐ ☐ ☐

No interference — Total interference

Do you need the help of your family and friends to complete everyday tasks (incl. both work outside the home and housework) because of your pain?

☐ ☐ ☐ ☐ ☐

Never need help — Need help all the time

Do you now feel more depressed, tense, or anxious than before your pain began?

☐ ☐ ☐ ☐ ☐

No depression/tension — Sever depression/tension

Are there emotional problems caused by your pain that interfere with your family, social, or work activities?

☐ ☐ ☐ ☐ ☐

No Problems — Severe problems

_____ _____

Patient's Signature **Date**