KAILUA
CHIROPRACTIC
FAMILY WELLNESS

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Auto Accident Form

Patient Information

Today's Date _____ Date of Collision _____

First Name _____
Last Name _____
DOB _____
Sex ◯ male ◯ female
SSN _____
Address _____
City _____
State _____
Zip Code _____

Phone 1 _____
◯ mobile ◯ home ◯ work
Phone 2 _____
◯ mobile ◯ home ◯ work
Email _____
Employer _____
Employer Phone _____
Occupation _____

Marital Status
◯ single ◯ married ◯ other

Working Status
◯ employed
◯ full-time student
◯ part-time student

Auto Insurance

Primary Insurance

Insurance Name _____
Insurance Phone _____
ID# _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____
Relationship to Insured ◯ self ◯ spouse ◯ child ◯ other

Secondary Insurance

Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____
Relationship to Insured ◯ self ◯ spouse ◯ child ◯ other

Accident History

When did the accident occur? _____ days ago _____ weeks ago _____ years ago other _____

Where were you located at the time of the accident? ◯ driver ◯ front passenger ◯ rear passenger ◯ pedestrian

If you were not the driver type the name, address and telephone number of the driver

How many passengers were in the accident vehicle? _____

Have you retained an attorney? ◯ yes ◯ no

Attorney Information

Attorney Name _____
Attorney Address _____
Attorney Phone _____

Driver of Other Vehicle Information

Other Driver Name _____
Other Driver Address _____
Other Driver Phone _____

Did anyone witness the accident? ◯ no ◯ one person ◯ two people ◯ three people ◯ several people

If yes, name, address and details of the witness or witnesses

Where did the accident occur? ◯ at an intersection ◯ in a parking lot ◯ in town ◯ on the interstate ◯ on a highway ◯ other _____

What is the make and model of your vehicle? _____

How many vehicles were involved in the accident? _____

What direction were you headed? ◯ north ◯ east ◯ south ◯ west

How fast was the vehicle going at time of impact? _____ mph

At impact, was the vehicle stopped, slowing down or speeding up? ◯ stopped ◯ slowing down ◯ speeding up

Was the other vehicle stopped, slowing down or speeding up? ◯ stopped ◯ slowing down ◯ speeding up

What time of day did the accident occur? ◯ morning ◯ afternoon ◯ evening ◯ night

How were the driving conditions at the time of the accident? ☐ normal ☐ dry ☐ icy ☐ stormy ☐ wet ☐ windy

What type of impact occurred? ☐ side-driver's ☐ side-passenger's ☐ front ☐ rear

Did the vehicle hit another structure after the accident? ☐ did not ☐ building ☐ ditch ☐ fire hydrant ☐ median ☐ pole ☐ railing ☐ second vehicle ☐ tree ☐ other _____

Was your vehicle struck by another vehicle? ◯ yes ◯ no

Did any part of your body strike anything in the vehicle? ☐ face ☐ jaw ☐ neck ☐ shoulders ☐ elbows ☐ chest ☐ hips ☐ legs ☐ shins ☐ knees ☐ feet ☐ other _____

Where were you looking at the time of impact? ◯ straight ahead ◯ to the left ◯ to the right ◯ up ◯ down

Which hands were on the steering wheel? ◯ none ◯ both hands ◯ left hand ◯ right hand

Which foot was on the brake? ◯ both ◯ neither ◯ left foot ◯ right foot

Which position was the headrest in? ◯ vehicle did not have a headrest ◯ low ◯ in mid-position ◯ high

What air bags deployed? ☐ no air bags deployed ☐ steering wheel air bag ☐ driver's side air bag ☐ passenger's side air bag

Were you wearing a seatbelt? ◯ yes ◯ no

What doors would not open as a result of the accident? ☐ all doors freely opened after accident ☐ front left ☐ front right ☐ rear left ☐ rear right ☐ other _____

What other treatment have you received for the accident?

Did you go to hospital? ◯ yes ◯ no

Hospital Information

Hospital Name _____ Hospital Location _____

Were you hospitalized overnight? ◯ yes ◯ no

Were you prescribed anything? ☐ arm brace ☐ crutches ☐ knee brace ☐ leg brace ☐ muscle relaxers ☐ neck brace ☐ pain medication ☐ topical analgesic ☐ wrist brace ☐ other _____

What services were performed at the hospital? ☐ none ☐ evaluation by a medical doctor ☐ X-rays ☐ MRI ☐ CT scan ☐ cast ☐ emergency life saving procedures ☐ blood transfusion ☐ stitches ☐ other _____

What types of diagnostic tests have been performed? ☐ amniocentesis ☐ basic metabolic panel ☐ biopsy ☐ CAT scan ☐ celiac profile ☐ colonoscopy ☐ complete blood count ☐ complete blood count with differential ☐ comprehensive metabolic panel ☐ diagnostic ultrasound ☐ echocardiogram ☐ electrolyte panel ☐ endoscopy ☐ extended cardiac risk profile ☐ hepatic function panel ☐ hepatitis panel, acute ☐ hepatitis panel, chronic ☐ lipid panel ☐ mammogram ☐ MRI ☐ OB profile ☐ PET scan ☐ renal panel ☐ urinalysis ☐ X-ray or X-ray series

Condition

What treatments have you received since the accident? ☐ ice ☐ heat ☐ oral pain medication ☐ topical analgesics ☐ muscle relaxers ☐ wrist brace ☐ knee brace ☐ neck brace ☐ ankle brace ☐ crutches ☐ other _____

How often have you been receiving treatment? ☐ daily ☐ twice per week ☐ three times per week ☐ four times per week ☐ five times per week ☐ weekly ☐ bi-weekly ☐ monthly

Details of treatment received

Location and provider where previous treatment was received

Are you responding to treatment? ☐ the same ☐ improving ☐ worse ☐ other _____

How did you feel immediately following the accident? ☐ head pain ☐ neck pain ☐ neck stiffness ☐ jaw/facial pain (TMJ) ☐ shoulder pain ☐ shoulder stiffness ☐ arm pain ☐ chest pain ☐ back pain ☐ low back pain ☐ lower limb pain ☐ back stiffness ☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling ☐ hands/fingers numbness or tingling ☐ upper limb numbness or tingling ☐ cold feet ☐ cold hands ☐ cold sweats ☐ constipation ☐ anxiety ☐ depression ☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented ☐ fainting ☐ fatigue ☐ forgetfulness ☐ impaired concentration ☐ irritability ☐ sensitivity to light ☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ loss of memory ☐ muscle spasms ☐ nauseous ☐ nervousness ☐ pins and needles ☐ restlessness ☐ shortness of breath ☐ sleeping problems ☐ stomach upset ☐ tension ☐ vision blurred ☐ weakness

What symptoms did you experience since the accident? ☐ head pain ☐ neck pain ☐ neck stiffness ☐ jaw/facial pain (TMJ) ☐ shoulder pain ☐ shoulder stiffness ☐ arm pain ☐ chest pain ☐ back pain ☐ low back pain ☐ lower limb pain ☐ back stiffness ☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling ☐ hands/fingers numbness or tingling ☐ upper limb numbness or tingling ☐ cold feet ☐ cold hands ☐ cold sweats ☐ constipation ☐ anxiety ☐ depression ☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented ☐ fainting ☐ fatigue ☐ forgetfulness ☐ impaired concentration ☐ irritability ☐ sensitivity to light ☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ loss of memory ☐ muscle spasms ☐ nauseous ☐ nervousness ☐ pins and needles ☐ restlessness ☐ shortness of breath ☐ sleeping problems ☐ stomach upset ☐ tension ☐ vision blurred ☐ weakness

Describe the pain? ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Does the pain travel anywhere else? ☐ denies radiating pain ☐ TMJ ☐ left TMJ ☐ right TMJ ☐ cranium (headache)
☐ left cranium (headache) ☐ right cranium (headache) ☐ cervical ☐ left upper cervical ☐ right upper cervical
☐ left lower cervical ☐ right lower cervical ☐ upper thoracic ☐ left upper thoracic ☐ right upper thoracic
☐ mid thoracic ☐ left mid thoracic ☐ right mid thoracic ☐ lower thoracic ☐ left lower thoracic ☐ right lower thoracic
☐ anterior rib ☐ left anterior rib ☐ right anterior rib ☐ posterior rib ☐ left posterior rib ☐ right posterior rib
☐ upper lumbar ☐ left upper lumbar ☐ right upper lumbar ☐ lower lumbar ☐ left lower lumbar ☐ right lower lumbar
☐ lumbosacral ☐ right lumbosacral ☐ left lumbosacral ☐ right sacroiliac ☐ left sacroiliac ☐ left anterior shoulder
☐ right anterior shoulder ☐ left posterior shoulder ☐ right posterior shoulder ☐ right arm ☐ left arm ☐ right elbow
☐ left elbow ☐ right forearm ☐ left forearm ☐ right wrist ☐ left wrist ☐ right hand ☐ left hand ☐ right hip
☐ left hip ☐ right leg ☐ left leg ☐ right thigh ☐ left thigh ☐ right knee ☐ left knee ☐ right calf
☐ left calf ☐ right ankle ☐ left ankle ☐ right foot ☐ left foot

Rate your pain on a scale of 0 to 10. *0 being no pain at all and 10 being the worst pain imagineable*

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How many days of work have you missed as a result of this accident? _____

Have you received X-rays for this accident? ○ yes ○ no

If yes, by whom?

If yes, which areas were X-rayed? ☐ skull (head) ☐ cervical (neck) ☐ thoracic (mid back) ☐ ribs ☐ lumbar (low back)
☐ sacral/pelvis ☐ chest ☐ abdomen ☐ left shoulder ☐ right shoulder ☐ left elbow ☐ right elbow
☐ left wrist ☐ right wrist ☐ left hand ☐ right hand ☐ left hip ☐ right hip ☐ left upper leg ☐ right upper leg
☐ left knee ☐ right knee ☐ left lower leg ☐ right lower leg ☐ left ankle ☐ right ankle ☐ left foot ☐ right foot

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____
And assign directly to the above named Chiropractic clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named Chiropractic clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

_____ Date _____
Signature of Patient, Parent, Guardian or Personal Representative

_____ Date _____
Print Name of Patient, Parent, Guardian or Personal Representative