Stone BridgeWellness

Automobile Accident Questionnaire

Accident Information

Name:_____ Date:_____

1. Date of Accident:_____ Time:_____ a.m./p.m.

2. Driver of car:_____ Where you were seated:_____

3. Owner of car:_____ Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: □ head-on collision □ broad-side collision □ rear-end collision

□ front impact, rear-ended car in front □ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? □ Yes □No

11. Did you brace for impact? □Yes □ No

12. Were you wearing a seatbelt? □ Yes □ No

13. Were you wearing a shoulder harness? □ Yes □ No

14. Does the car have headrests? □ Yes □ No

15. If yes, what was the position of your headrest? □ top of headrest even with bottom of head

□ top of headrest even with top of head □ top of headrest even with middle of head

16. Was your car braking? □ Yes □ No Was the other car braking? □Yes □ No

17. Was your car moving at the time of the accident? □ Yes □ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

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19. What was the position of your head and body at the time of impact?

□ head turned left/right □ body straight in sitting position □ head looking back

□ body rotated left/right □ head straight forward □ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: □ rendered unconscious □ dazed □ other: _____

22. Could you move all parts of your body? □yes □ no

If no, why? _____

23. Were you able to get out of the car and walk unaided? □ yes □ no

If no, why? _____

24. Did you have any cuts or bruises from this accident? □ yes □ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that □ day □night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

□ headache	□ loss of smell	□ numbness in fingers	□ neck pain/stiffness
□ loss of taste	□ cold hands	□mid-back pain	□ loss of memory
□ cold feet	□ low-back pain	□ fatigue	□ diarrhea
□ tension	□ constipation	□ pain behind eyes	□ shortness of breath
□ chest pain	□ dizziness	□ irritability	□ nervousness
□ fainting	□ depression	□ cold sweats	□ anxious
□ sleeping problems	□ loss of balance	□ numbness in toes	
□ ringing/buzzing in ears		□ eyes sensitive to light	□ other:_____

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27. Have you missed time from work? □ yes □ no Work hours are: □ full-time □ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? □ yes □ no

29. Did you seek medical help immediately/soon after the accident? □ yes □ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen:_____Date: _____

31. What was done? _____

Were x-rays taken? □ yes □ no If yes, of what body part? _____

32. What treatments/prescriptions were given? □ bed rest □ brace □ adjustments □ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

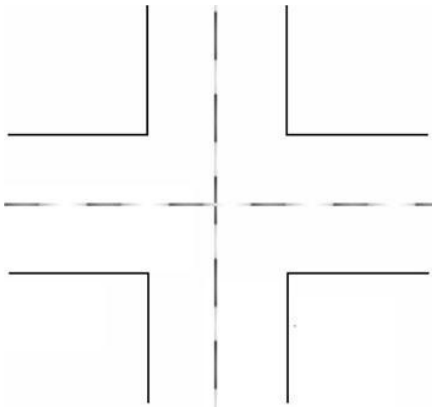
35. Are any of your activities of daily living any different now compared to before the accident?
□ yes □ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

_____

_____

_____

37. Do you have an attorney handling this case? □ yes □ no

If yes, who? (name/address)_____

_____

Insurance Information

Patient's PERSONAL insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address:_____City:_____State/Zip:_____

Claim #:_____

Adjuster's name/phone:_____

OTHER party's insurance: _____

Insured's name (if other than patient)_____Policy #: _____

Insurance Company Name:_____Phone#: _____

Address:_____City:_____State/Zip: _____

Claim #: _____Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address:_____City:_____State/Zip: _____

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Claim #: _____

Adjuster's name/phone: _____

Patient's Information
Patient's full name: _____

Address: _____

Date of Birth: _____Social Security #:_____

Mailing address (if different): _____

Phone: _____ Email address:_____

Marital Status: _____ Patient's Occupation: _____

Employer's Name:_____

Employer's address: _____

Work phone #: _____ Work Email address:_____

Spouse's name:_____

Spouse's Social Security #:_____ Spouse's Email: _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Stone Bridge Wellness** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **Stone Bridge Wellness** the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay **Stone Bridge Wellness** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date:_____

Printed name: _____

Witness:_____

Auto Accident Injury Information **NAME:**_____ **DATE:**_____

What was your position in the vehicle?

( ) The driver ( ) The rear passenger
( ) The front passenger ( ) A pedestrian ( ) Other: _____

What type of vehicle were you driving?

( ) Compact car ( ) Full size car ( ) Full size truck ( ) Full size van
( ) Mid size car ( ) Compact truck ( ) Mini van ( ) Compact sport utility vehicle
( ) Full size sport utility vehicle ( ) Motorhome
( ) Motorcycle ( ) Bicycle ( ) Other: _____

What speed were you traveling at the time of the accident?

( ) Stopped at a stop light ( ) At a complete stop
( ) Slowing down at an intersection ( ) Moving slowly
( ) Traveling at approximately ___ mph ( ) Merging into traffic
( ) Traveling faster than 65 mph ( ) Other: _____

Who hit whom?

( ) Was struck by another vehicle ( ) Struck a stationary object
( ) Struck another vehicle ( ) Other: _____

What was your vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear ( ) On the left rear
( ) On the right front ( ) On the middle front ( ) On the right rear ( ) On the middle rear

( ) On the right side ( ) On the rear right side ( ) On the left side
( ) On the front right side ( ) On the middle right side ( ) On the front left side

( ) On the rear left side
( ) On the middle left side ( ) Other: _____

What speed was the other vehicle traveling?

( ) Stopped at a stop light ( ) At a complete stop
( ) Slowing down for an intersection ( ) Moving slowly
( ) Merging into traffic ( ) Traveling faster than 65 mph
( ) Traveling at approximately ___ mph ( ) Other: _____

What was the other vehicle's point of impact?

( ) On the front
( ) On the left front
( ) On the rear
( ) On the right front
( ) On the middle front
( ) On the right rear

( ) On the left rear
( ) On the right side
( ) On the rear right side
( ) On the middle rear
( ) On the front right side
( ) On the middle right side

( ) On the left side
( ) On the rear left side
( ) On the front left side
( ) On the middle left side
( ) Other: _____

Were you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint
( ) Was wearing a shoulder restraint
( ) Was wearing a lap restraint
( ) Was not wearing any seat restraints
( ) Other: _____

What position were your vehicle head rests in?

( ) Did have a head rest which was adjusted in the lowest position
( ) Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position
( ) Was not equipped with a head rest
( ) Other: _____

Did your air bag deploy?

( ) Air bags were deployed
( ) Other:_____
( ) Air bags were not deployed

Were you prepared for the impact?

( ) Was completely surprised by the accident
( ) Saw the collision coming and braced appropriately
( ) Saw the collision coming
( ) Other: _____

What position was your body in just prior to impact?

( ) A straight position
( ) A position rotated to the left
( ) A tilted forward position
( ) A position rotated to the right
( ) A position that cannot be remembered
( ) Other: _____

What happened to your body the moment of impact?

( ) Body was tensed for impact
( ) Body whipped violently forward and backward
( ) Body was thrown from the vehicle
( ) Body was pinned in the vehicle
( ) Body violently torqued and twisted
( ) Body was thrown over the seat
( ) Body was thrown from side to side
( ) Body was badly cut and bruised
( ) Other: _____

What was your mental/emotional state immediately following the accident?

( ) Was not rendered unconscious by the impact of the accident
( ) Was not rendered unconscious but was shaken and disoriented
( ) Was not rendered unconscious but was shaken up
( ) Was not rendered unconscious but was disoriented
( ) Was rendered unconscious by the impact of the accident
( ) Other: _____

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention
( ) Did not receive medical attention
( ) Other: _____

Where did you go immediately following the accident?

( ) Was taken to the hospital
( ) Was taken home
( ) Resumed activities
( ) Was taken to a personal physician
( ) Was taken to this office
( ) Other: _____

List each of your body parts that struck the following vehicle parts during the accident.

Dashboard:

( ) Right side of the head
( ) Right shoulder
( ) Left side of the head
( ) Left shoulder
( ) Right arm
( ) Right elbow
( ) Left arm
( ) Left elbow
( ) Right wrist
( ) Right hip
( ) Left wrist
( ) Left hip
( ) Right knee
( ) Right ankle
( ) Left knee
( ) Left ankle
( ) Other: _____

Windshield:

( ) Right side of the head
( ) Right shoulder
( ) Left side of the head
( ) Left shoulder
( ) Right arm
( ) Right elbow
( ) Left arm
( ) Left elbow
( ) Right wrist
( ) Right hip
( ) Left wrist
( ) Left hip
( ) Right knee
( ) Right ankle
( ) Left knee
( ) Left ankle
( ) Other: _____

Steering Wheel:

( ) Right side of the head	( ) Right arm	( ) Right wrist	( ) Right knee
( ) Right shoulder	( ) Right elbow	( ) Right hip	( ) Right ankle
( ) Left side of the head	( ) Left arm	( ) Left wrist	( ) Left knee
( ) Left shoulder	( ) Left elbow	( ) Left hip	( ) Left ankle
( ) Other: _____			

Right Door:

( ) Right side of the head	( ) Right arm	( ) Right wrist	( ) Right knee
( ) Right shoulder	( ) Right elbow	( ) Right hip	( ) Right ankle
( ) Left side of the head	( ) Left arm	( ) Left wrist	( ) Left knee
( ) Left shoulder	( ) Left elbow	( ) Left hip	( ) Left ankle
( ) Other: _____			

Left Door:

( ) Right side of the head	( ) Right arm	( ) Right wrist	( ) Right knee
( ) Right shoulder	( ) Right elbow	( ) Right hip	( ) Right ankle
( ) Left side of the head	( ) Left arm	( ) Left wrist	( ) Left knee
( ) Left shoulder	( ) Left elbow	( ) Left hip	( ) Left ankle
( ) Other: _____			

Seat Frame:

( ) Right side of the head	( ) Right arm	( ) Right wrist	( ) Right knee
( ) Right shoulder	( ) Right elbow	( ) Right hip	( ) Right ankle
( ) Left side of the head	( ) Left arm	( ) Left wrist	( ) Left knee
( ) Left shoulder	( ) Left elbow	( ) Left hip	( ) Left ankle
( ) Other: _____			

Unknown Object:

( ) Right side of the head	( ) Right arm	( ) Right wrist	( ) Right knee
( ) Right shoulder	( ) Right elbow	( ) Right hip	( ) Right ankle
( ) Left side of the head	( ) Left arm	( ) Left wrist	( ) Left knee
( ) Left shoulder	( ) Left elbow	( ) Left hip	( ) Left ankle
( ) Other: _____			