Automobile Accident Questionnaire
Integrated Physical Medicine, LLC

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? _____

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 not? _____

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

If no, why not? _____

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:_____

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: _____

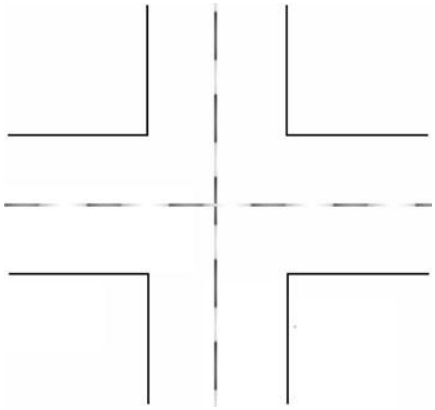
35. Are any of your activities of daily living any different now compared to before the accident?
□ yes □ no

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/Phone Number)_____

_____

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: _____

Claim #: _____

Adjuster's name/phone: _____

Patient's Demographic Information

Patient's full name and Social Security #: _____

Address: _____

Date of Birth: _____

Mailing address (if different): _____

Phone: _____

Employer name: _____

Spouse's Occupation: _____

Employer's address: _____

Work phone: _____

Spouse's name: _____

Spouse's Social Security #: _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Integrated Physical Medicine, LLC any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Integrated Physical Medicine, LLC 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 Integrated Physical Medicine, LLC 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: _____