

# 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 help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case in order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_  
(indicate if child, student, housewife, unemployed, retired)  
Social Business Company  
Sec. #: \_\_\_\_\_ Phone: \_\_\_\_\_ Name \_\_\_\_\_ Location \_\_\_\_\_  
Spouse's Spouse's Spouse's  
First Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_ Employer \_\_\_\_\_ Location \_\_\_\_\_  
Please explain in detail how your accident happened \_\_\_\_\_

What were the time and date of present injury? \_\_\_\_\_  
Where did you feel pain immediately after the accident? \_\_\_\_\_  
List the extent of injuries as you know them: \_\_\_\_\_

Did you require post accident hospitalization?  Yes  No

Check symptoms you have noticed since the accident:

- |                                       |                                                   |                                          |                                               |
|---------------------------------------|---------------------------------------------------|------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Headache     | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Depression      | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Light Bothers Eyes       | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Neck Pain    | <input type="checkbox"/> Head Seems too Heavy     | <input type="checkbox"/> Loss of Memory  | <input type="checkbox"/> Feet Cold            |
| <input type="checkbox"/> Neck Stiff   | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring       | <input type="checkbox"/> Hands Cold           |
| <input type="checkbox"/> Fainting     | <input type="checkbox"/> Sleeping Problems        | <input type="checkbox"/> Loss of Balance | <input checked="" type="checkbox"/> Back Pain |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Tension              |
| <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Fever                |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Chest Pain           |
| <input type="checkbox"/> Cold Sweats  | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> _____           | <input type="checkbox"/> _____                |

Symptoms other than above: \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Hospitalized?  Yes  No If yes, were you admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Doctors \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No

If so, what was the doctor's name? \_\_\_\_\_  D.C.  M.D.  D.O.

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How long and how often did you see the doctor? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others of your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms  improving?  getting worse?  same?

Name \_\_\_\_\_ Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
(driver of vehicle in which you were injured, if not you)

Your Name \_\_\_\_\_ Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his name and address \_\_\_\_\_

You were heading  North  East  South  West on \_\_\_\_\_ (st. c  
Other vehicle was heading  North  East  South  West on \_\_\_\_\_ (st. c

Were police notified?  Yes  No

Were you knocked unconscious?  Yes  No If so, for how long? \_\_\_\_\_

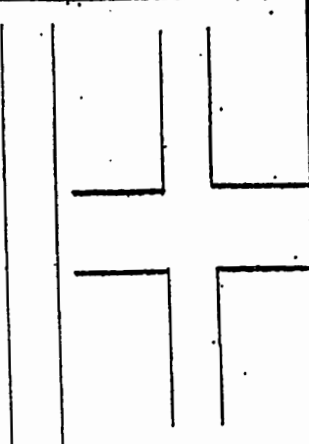
You were struck from  Behind  Front  Left Side  Right Side

You were  Driver  Passenger  Front seat  Back seat  Using seat belts  Other

**INDICATE ON THIS DIAGRAM WHAT HAPPENED**

Use this space to sketch the scene of your accident. Writing in street or highway names or numbers.

1. Number each vehicle and show direction of travel with arrows.
2. Use solid lines to show path before accident and dotted line after accident.
3. Show pedestrians with: ○
4. Show railroads
5. Show distance, direction to landmarks; identify landmarks by name or #.
6. Indicate north with an arrow.



I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in my collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable by me.

Patient's Signature: \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME:

## ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. \_\_\_\_\_ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)