Moore Chiropractic Clinic

1709 NE 27th St., Suite H • McMinnville, OR 97128

Halley Moore, D.C. • Phone: 503-472-1477 • Fax: 503-472-1478

RETURN THIS FORM TO BILLING OFFICE

MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name: _____ Date of Birth: _____

Date of Accident: _____ Today's Date: _____

INSURANCE INFORMATION

Name of Policy Holder _____

Name of Policy Holder's Insurance Company: _____

Phone Number: _____

CLAIMS OFFICE

Address: _____

Phone Number: _____

Claim Representative's Name: _____

Claim Number: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the Moore Chiropractic Clinic to furnish my records to the insurance company or an attorney for the purpose of obtaining payment on my account for the service(s) provided to me. In addition, the undersigned hereby authorizes payment directly to Moore Chiropractic Clinic for all medical benefits otherwise payable to the undersigned or the patient.

I understand that I am responsible for all charges incurred at Moore Chiropractic Clinic regardless of my insurance coverage.

Patient or Guardian Signature: _____ Date: _____

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AUTO ACCIDENT QUESTIONNAIRE

Patient's Name _____ **Today's Date** _____

1. Date of Accident _____ Time of Accident _____ ☐ AM ☐ PM
2. Name of Driver of Car _____ Where were you seated? _____
3. Type of Accident: ☐ head-on collision ☐ broad-side collision
   ☐ rear-end collision ☐ front impact, rear-ended car in front
   ☐ non-collision (describe: _____)
4. Describe, in your own words, what happened to you upon impact: _____
   _____
5. Did you brace for impact? ☐ Yes ☐ No
6. Were shoulder harnesses worn? ☐ Yes ☐ No
7. Were seat belts worn? ☐ Yes ☐ No
8. Was the car braking? ☐ Yes ☐ No
9. Does the car have headrests? ☐ Yes ☐ No
   If yes, what was the position of the headrest compared to your head before the accident?
   The top of the headrest was even with: ☐ TOP of head ☐ BOTTOM of head ☐ middle of NECK
10. Was the car moving at the time of the accident? ☐ Yes ☐ No
    If yes, how fast would you estimate that you were going? _____ mph
11. How fast was the other car traveling? _____ mph
12. Head/body position at the time of impact: ☐ head turned __left / __right ☐ head looking back
    ☐ body straight in sitting position ☐ body rotated __left / __right ☐ head straight forward
    ☐ other (describe: _____)
13. At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car:
    _____
    _____
14. As a result of the accident, you were: ☐ rendered unconscious ☐ dazed, circumstances vague
    ☐ other (describe: _____)
15. Could you move all parts of your body? ☐ Yes ☐ No *If no*, what parts and why? _____
    _____
    _____
16. Were you able to get of the car and walk unaided? ☐ Yes ☐ No *If no*, why not? _____
    _____
17. What bleeding cuts did you get from this accident? _____
18. What bruises did you get from this accident? _____

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19. Describe how you felt immediately after the accident. Please be specific. _____

_____

20. Describe how you felt later that ☐ day ☐ night _____

_____

21. Describe how you felt the next ☐ day ☐ days _____

_____

22. Check symptoms that have been apparent since the accident:

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

23. Occupation _____ Employer_____

24. Have you missed time for work? ☐ Yes ☐ No If yes, please indicate date range:

full-time off work _____ to _____

part-time off work _____ to _____

25. Did you seek medical help immediately / soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ someone drove me ☐ drove my own car ☐ ambulance ☐ police

☐ other _____

26. Doctor / Hospital / Clinic seen: _____

_____ Date _____

27. Were you examined? ☐ Yes ☐ No

28. Were x-rays taken? ☐ Yes ☐ No If yes, what body part(s) _____

29. What treatment was given to you? ☐ bed rest ☐ brace ☐ physiotherapy ☐ drugs ☐ adjustments

☐ other _____

30. What benefits did you receive from the treatment(s)? _____

_____

31. Date of last treatment: _____

32. Have you sought or had any treatment other than the doctor listed above? ☐ Yes ☐ No

Doctor / Hospital / Clinic seen: _____

33. Did you have any physical complaints just before the accident? ☐ Yes ☐ No If yes, please describe in detail:

_____