RIVERWOODS CHIROPRACTIC & MASSAGE PLLC

Motor Vehicle Accident Questionnaire

Name_____ Date_____

Date of Accident _____ Time of Accident_____☐AM ☐PM Was the accident work related? ☐Yes ☐No

Address where accident occurred? _____

Were you the: ☐Driver ☐Front Passenger ☐Rear Passenger ☐Other _____ Number of people in accident vehicle _____

Type of Collision: ☐Head On ☐Rear End ☐Broad Side ☐Front Impact, rear ended car in front of you ☐Other _____

Did the impact to your vehicle come from the: ☐Front ☐Rear ☐Right Side ☐Left Side ☐Other _____

What did your vehicle impact? ☐Another Vehicle ☐Nothing ☐Other _____

Did the police come to the accident site? ☐Yes ☐No Was the police report filed? ☐Yes ☐No

Was a citation/ticket issued? ☐Yes ☐No If yes, to whom and what for? _____

Were you wearing a seat belt? ☐Yes ☐No Was the car equipped with air bags? ☐Yes ☐No Did they deploy/inflate? ☐Yes ☐No

Did part of your body strike anything in the vehicle? ☐Yes ☐No If yes please describe: _____

In relation to your skull where was the headrest located? ☐Above ☐Below ☐At Base of Skull ☐Other _____

During the impact, were you facing? ☐Forward ☐Right ☐Left ☐Other _____

Were you aware of the oncoming impact? ☐Yes ☐No Did you brace for the impact? ☐Yes ☐No

Was your foot on the brake at impact? ☐Yes ☐No Was your foot on the clutch at impact? ☐Yes ☐No

Make, model and year of vehicle you were occupying? _____

Make, model and year of other vehicle(s) involved in the accident? _____

What was the approximate speed of your vehicle? _____mph Approximate speed of the other vehicle? _____mph

In your own words, please describe the accident in detail:

Did the accident render you unconscious? ☐Yes ☐No If yes, how long? _____

Please describe how you felt after the accident? _____

Have you gone to another hospital/doctor for this accident? ☐Yes ☐No Name of hospital/doctor: _____

When did you go? ☐Just After Accident ☐Next Day ☐More than Two Days How did you get there? ☐Ambulance ☐Private Auto

Were x-rays taken? ☐Yes ☐No If yes, of what area? _____

Was medication prescribed? ☐Yes ☐No If yes, what kind/how often? _____

Describe any treatment you received: _____

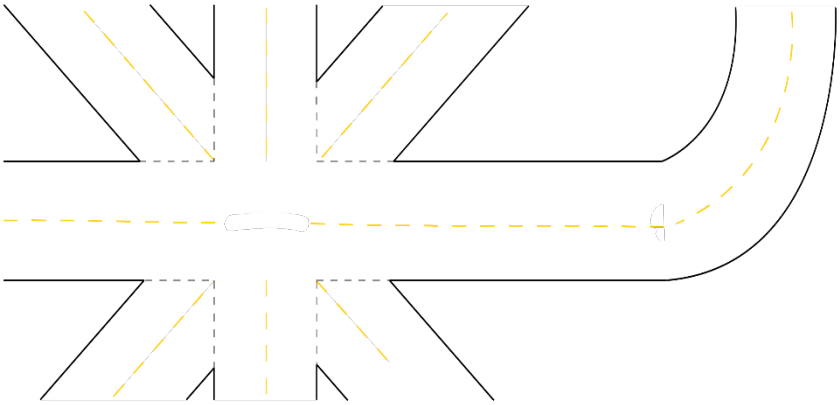
Have you been able to work since the accident? ☐Yes ☐No Please describe any work/daily limitations: _____

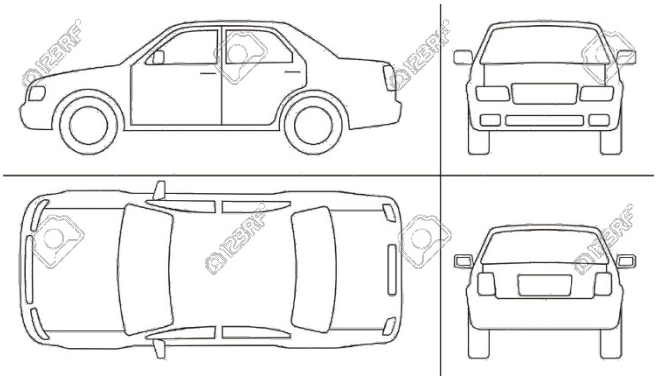
Indicate symptoms that are a result of the accident:

☐Dizziness	☐Headaches	☐Blurred Vision	☐Ears Ringing		
☐Tension	☐Arm/Shoulder Problems	☐Jaw Problems	☐Neck Pain	☐ Numb Hands/Fingers	☐Chest Pain
☐Nausea	☐Memory Loss	☐Back Pain	☐Back Stiffness	☐Leg Pain	☐Fatigue
☐Irritability	☐Numb Foot/Toes	☐Upset Stomach	☐Buzzing in Ear	☐Other _____	

Is your condition worsening? ☐Yes ☐No ☐Comes and Goes ☐Constant

Below, please depict what occurred at the time of the motor vehicle accident you were involved in, including what damages were made to your vehicle if any. The picture may include things like signs, speed limits, stop lights, etc.





Insurance Information

Personal Injury Protection (PIP): This is a type of insurance that will help pay for your own medical costs after a car accident, regardless of who was at fault for the accident. You should file a claim with your PIP. This ensures that any medical bills be paid up front and you would not be responsible for any out-of-pocket expense up to your policy limits.

Do you have personal injury protection? ☐Yes ☐No ☐Unsure

Name of your car insurance company: _____

Ins. Company's Address: _____ Claim # _____

Adjuster's Name: _____ Adjuster's Phone Number: _____ Fax: _____

Third Party: After filing a claim with your PIP (if applicable), you should also file a claim with the other party's insurance. This is called a"3rd Party Claim". They will settle with you for a dollar amount when you are done treating for any medical conditions related to the MVA.

Was a third party at fault for the accident that occurred? ☐Yes ☐No ☐Unsure

If yes, name of their car insurance company: _____

Ins. Company's Address: _____ Claim # _____

Adjuster's Name: _____ Adjuster's Phone Number: _____ Fax: _____

Attorney:

Do you have an attorney? ☐Yes ☐No

If yes, name of attorney's office: _____

Personal Health Insurance: Your personal health insurance is used after your personal injury protection policy limit exhausts, if there is only a third-party claim open, and/or when no personal injury protection or third party are present.

Do you have personal health insurance? ☐Yes ☐No ☐Unsure

If yes, name of your personal health insurance company: _____

Personal Health Ins. ID # _____ Group # (if applicable) _____