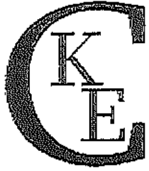


Kent-East Chiropractic Clinic
10830 SE Kent-Kangley Rd, Ste 101, Kent, WA 98030 253.854.3040

MOTOR VEHICLE ACCIDENT HISTORY FORM

Please Print Date: ____________

Name: (L)________________________(F)____________________(M)________________

Address ____ Apt # ______________

City ___________________________ State _________________ Zip Code ____________

Home / Cell ___________________________ Cell / Work ______________________

Email Address ____

Birth Date __________________ Sex: M [ ] F [ ] Social Security # ____________________

Accident Date: ____________________ Were the police notified? _____________________

Was an accident report filed? ____________________ Report Number: ____________________

Who was the at fault party? Self [ ] Driver in same car [ ] Driver of other car [ ] Unknown [ ]

Was this accident a hit and run? ____

YOUR automotive insurance information.

Insurance Name: _____________________________ Do you have PIP? __________________

Claim Number: ______________________________ Claims Adjuster: __________________

Adjuster's Number: ___________________________ Insurance Policy Number: ____________

Information from the vehicle YOU were in during the accident. (skip if same as above)

Insurance Name: _____________________________ Does the policy have PIP? ____________

Claim Number: ______________________________ Claims Adjuster: __________________

Adjuster's Number: ___________________________ Insurance Policy Number: ____________

Driver of the other vehicle.

Driver Name: ________________________________ Driver Number: ____________________

Driver Address: ____

Vehicle Make: ________________ Model: ____________ Year: ________________________

Insurance Name: ____

Claim Number: ______________________________ Claims Adjuster: __________________

Adjuster's Number: ___________________________ Insurance Policy Number: ____________

Attorney Information

Have you retained an attorney? ______________________________

If no, would you like information on local attorneys? ______________________________

If yes, which attorney have you hired? ______________ Phone Number ______________

When / Where / Conditions

The vehicle YOU were in during the accident: Year: ______ Make: ______ Model: ______

State of occurrence: ______________________________

Light Conditions: Dawn [ ] Daylight [ ] Dusk [ ] Night/Dark [ ]

Road Conditions: Dry [ ] Wet [ ] Ice [ ] Gravel [ ] Other: ______________

Weather Conditions: Clear [ ] Rain [ ] Fog [ ] Cloudy [ ] Overcast [ ] Snow [ ]

Other: ______________________________

Description on the Accident

Please describe the accident: ______________________________

____

____

____

____

Vehicle position before impact	Vehicle position after impact

Nature of the Accident

Does the vehicle you were in have: Automatic [ ] Or Manual [ ] Transmission

Where were you seated in the vehicle?

Driver [ ]

Front Passenger: Middle [ ] By Door [ ]

Rear Passenger: Right [ ] Middle [ ] Left [ ]

Other: ______________________________

Nature of the Accident (cont.)

Were you wearing a seatbelt? YES NO If yes, Lap belt [ ] Shoulder Belt [ ] Both [ ]

Did you receive any injury or bruise from the seat belt? ______________________

____

Does your vehicle have a head rest? Yes [ ] No [ ] If yes, was it High [ ] Middle [ ] Low [ ] Integral [ ]

Was the driver applying the break at impact? Yes [ ] No [ ] Don't know [ ]

Was your vehicle stopped at impact? Yes [ ] No [ ] Don't know [ ]

If your vehicle was moving at impact, was it?

Slowing Down? Yes [ ] No [ ]

Gaining Speed? Yes [ ] No [ ]

Traveling at a steady speed? Yes [ ] No [ ]

Estimate the speed of the vehicle you were in: ____________ MPH [ ] or KM [ ]

Was the other vehicle moving at impact? Yes [ ] No [ ] Don't know [ ]

Were you aware of the approaching collision, or did the impact catch you by surprise?

Aware [ ] Surprise [ ]

Was your head pointed straight at impact? Yes [ ] No [ ] If no, turned Right [ ] Left [ ]

Was the trunk of your body pointed straight at impact? Yes [ ] No [ ]

If no, turned Right [ ] Left [ ]

Did your body go: forward then backward [ ] backward then forward [ ] Other: ________

On what part of the vehicle did your following body parts hit?

Head ____________ Chest ____________

Right Shoulder ____________ Left Shoulder ____________

Right Elbow ____________ Left Elbow ____________

Right Arm ____________ Left Arm ____________

Right Hip ____________ Left Hip ____________

Right Leg ____________ Left Leg ____________

Right Knee ____________ Left Knee ____________

Other ____________ Other ____________

Did you lose consciousness (black out) upon or after impact? Yes [ ] No [ ]

Nature of the Accident (cont.)

Please indicate if and when you experienced any of the following symptoms after the accident by placing the appropriate letter next to the symptom. I = Immediately H= First appeared ______ hours after the accident. D = First appeared ______ days after the accident.

Light Headed [ ] Ring/Buzz in Ears [ ] Disoriented [ ] Confused [ ] Dizzy [ ]

Nauseated [ ] Blurred Vision [ ] Headache [ ] Numbness [ ]

Neck Pain/Stiffness [ ] Back Pain/Stiffness [ ] Low Back Pain/Stiffness [ ]

If you still have any of these symptoms, which ones? ____________________

____

Which of the following car parts broke during the accident?

Windshield [ ] Front Seat [ ] Back Seat [ ] Steering Wheel [ ] Right Window [ ]

Left Window [ ] Other: ____________________

Was your vehicle: Drivable [ ] Not Drivable [ ] Totaled [ ]

Estimated dollar damage to vehicle? ____________________

Medical Treatment Resulting from the Accident

Did you receive emergency care at the accident site? Yes [ ] No [ ]

Did you go to the hospital? Yes [ ] No [ ] If yes, when? ____________________

Name of hospital: ____________________

How did you get to the hospital? ____________________

What did the hospital do for your injuries? ____________________

Were you scheduled for follow up care? ____________________

What bleeding cuts did you sustain during the accident? ____________________

What bruised did you sustain during the accident? ____________________

Have you been examined or treated by a doctor since the accident? If yes, who/when/where?

____

____

____

____

What medications are you currently taking? ____________________

____

Medical Treatment Resulting from the Accident (cont.)

Are you currently suffering from any of the following?

Reduced tolerance to alcohol [ ] Irritability [ ] Difficulty concentrating [ ]

Restlessness [ ] Difficulty with memory [ ] Sleeplessness [ ]

Reduced tolerance to heat [ ] Forgetfulness [ ]

Did you have any physical complaints before the accident? Yes [ ] No [ ], I was otherwise healthy

If yes, please describe: ______________________________

____

____

Time Loss / Activity Restrictions

At the time of injury:

Employer ______________ Occupation ______________ Years employed ________

Current

Employer ______________ Occupation ______________ Years employed ________

Have you lost any time from work as a result of the accident? Yes [ ] No [ ]

If yes, last day worked? ______________ Day returned to work? ______________

Have you been released for work by a doctor? Yes [ ] No [ ]

If yes, are you released with restrictions? Describe: ______________________________

Are you still on restricted work release? Yes [ ] No [ ]

Past Medical History (have you EVER at anytime in your life?)

Hospitalization: None [ ] Yes: ______________________________

____

Surgery/Operations: None [ ] Yes: ______________________________

____

Serious Illness: None [ ] Yes: ______________________________

____

Allergies: None [ ] Yes: ______________________________

____

Fractures: None [ ] Yes: ______________________________

____

Past Medical History (cont.)

Work related injury: None [ ] Yes:____

____

Automobile Accidents: None [ ] Yes: ______________________________________

____

Prior Treatment by a Chiropractor: None [ ] Yes:______________________________

____

Prior History of Current Complaints: None [ ] Yes:____________________________

____

Please check any of the following diagnosed conditions (conditions your doctor treated you for or told you that you had) that you had in the past or currently have. If you were diagnosed with a condition that does not appear in the following list please indicate under OTHER.

Stroke [ ] Multiple Sclerosis [ ] Epilepsy [ ] Low Blood Pressure [ ] Arthritis [ ]

Heart Disease [ ] Hernia [ ] High Blood Pressure [ ] Asthma [ ] Diabetes [ ]

Gout [ ] Hypothyroid [ ] Cancer [ ] Tuberculosis [ ] Polio [ ] Hyperthyroid [ ]

Other: ____

____

Personal and Social History

Marital Status: M [ ] W [ ] D [ ] S [ ] Spouse's Name____________________

Children: None [ ] How many?______________________________________

Do you currently smoke? Yes [ ] No [ ]

If yes, how much?________________How long?______________________

If no, have you ever smoked? Yes [ ] No [ ]

How much?__________When did you quit? __________

Military service? Yes [ ] No [ ]

If yes, did you sustain any injuries in the performance of your duties? Yes [ ] No [ ]

Please list injuries sustained in performance of your duties: ________________________

____

____

Family Medical History

	Arthritis	Cancer	Strokes	Diabetes	Epilepsy	Heart Disease	Multiple Sclerosis	High Blood Pressure	Other:
Mother									
Father									
Sister									
Brother									

All first visit charges are payable in full when the services are rendered.

The fee paid for the x-rays is for analysis only. The film itself remains property of this office.

I understand and agree that health and accident insurance policies are an agreement between the insurance company and me. Furthermore, I understand Kent-East Chiropractic will prepare any necessary reports and/or forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Kent-East Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment. Also, if applicable, I authorize Kent-East Chiropractic to provide any care that is medically necessary to my dependent (listed above as patient).

Patient's Signature ______________________ Date ____________

Guardian's Signature ______________________ Date____________

In case of emergency, please notify (nearest relative not living with you): ____________

Relationship ____________ Phone number & Address ____________

____

FOR OFFICE USE ONLY:

Prior patient account number: ______________________

Account numbers for others involved in case: ______________________

PIP Adjuster contacted: Yes [ ] No [ ] PIP verified: Yes [ ] No [ ] $MAX:________

Attorney contacted: Yes [ ] No [ ]

Patient briefed on office and billing procedures regarding case: Yes [ ] No [ ] Initials:______

Special Instructions or Limitations: ______________________

____

Completed By: ______________________Date: ____________

Assignment and Authorization to Pay Doctor

I hereby assign to and authorize ______________________________
(Insurance Company Name)
to pay my account by check made out and mailed directly to the following:

KENT-EAST CHIROPRACTIC CLINIC
10830 Kent-Kangley Road, Suite 101
Kent, WA 98031

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail as follows:

____
Patient Name
C/O KENT-EAST CHIROPRACTIC CLINIC
10830 Kent-Kangley Road, Suite 101
Kent, WA 98031

the professional or medical benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

____
Policy Number

____
Name of Insured

______________________________ Date ______________
Patient Signature

______________________________ Date ______________
Parent/Guardian Signature (if patient is a minor)

FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

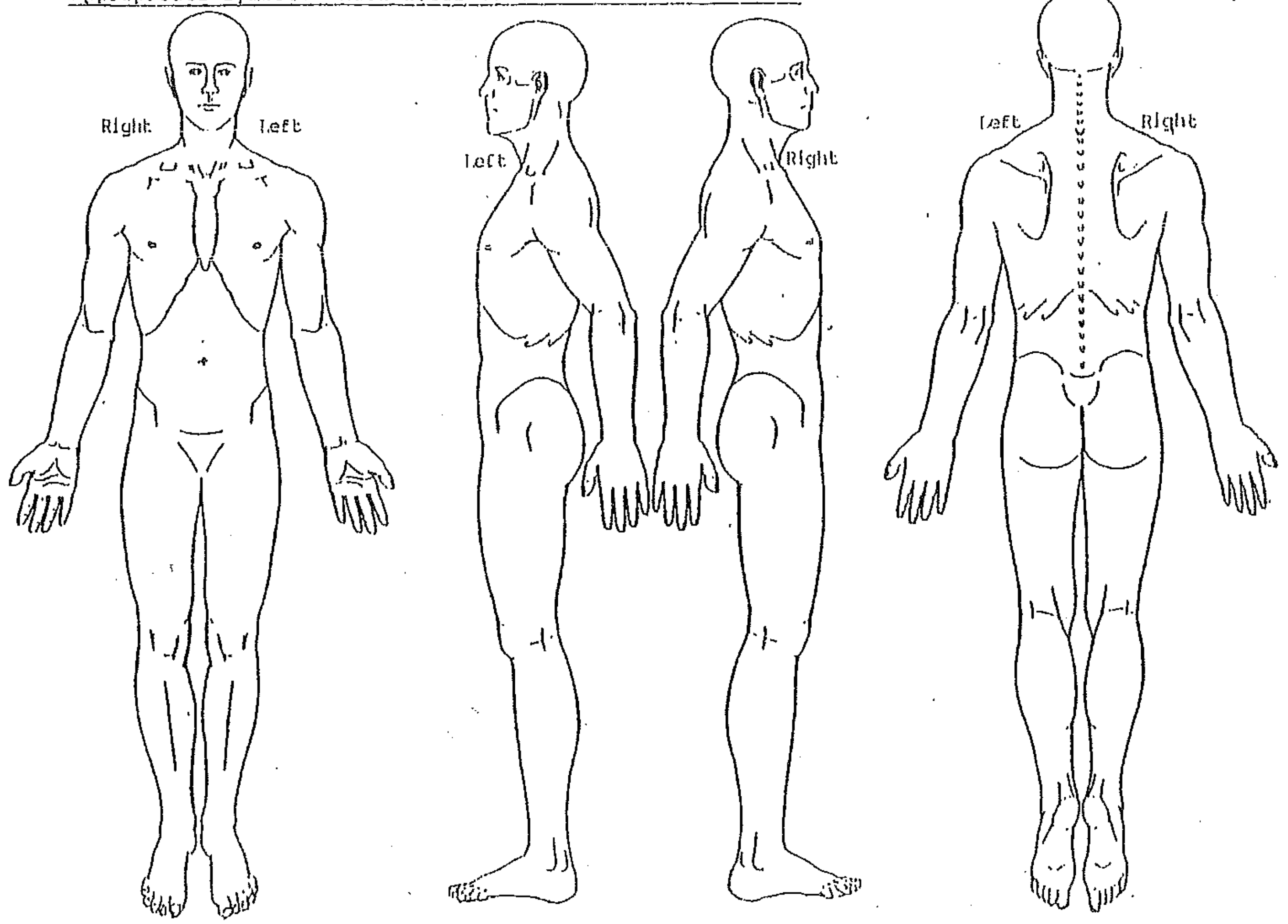
		0	1	2	3	4
1.	Pain Intensity:	None	Mild	Moderate	Severe	Worst possible pain
2.	Frequency of Pain:	None	Occasional 25% of the day	Intermittent 50% of the day	Frequent 75% of the day	Constant 100% of the day
3.	Sleeping:	Perfect Sleep	Mildly Disturbed Sleep	Moderate Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep
4.	Personal Care: (Washing, Dressing, etc)	No Pain No restrictions	Mild Pain No restrictions	Moderate Pain, need to go slow	Need some assistance	Severe need 100% assistance
5.	Travel, Driving or riding:	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
6.	Work:	Can do usual work plus extra work	Can do usual work, no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot Work
7.	Recreation:	Can do all activities	Can do most activities	Can do some activities	a few activities activities	Cannot do any activities
8.	Lifting:	No Pain with heavy weight	Increased pain w/heavy weight	Increased pain w/moderate wt.	Increased pain w/light weight	Increased pain w/any weight
9.	Walking:	No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain all walking
10.	Standing:	No pain after several hours	Increased pain after several hrs	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain any standing

Print Patient Name: ______________________

Patient Signature: ______________________ **Date:** ____________

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
Z Z Z	B B B	X X X X	= = =	////
Z Z Z	B B B	X X	= = =	///

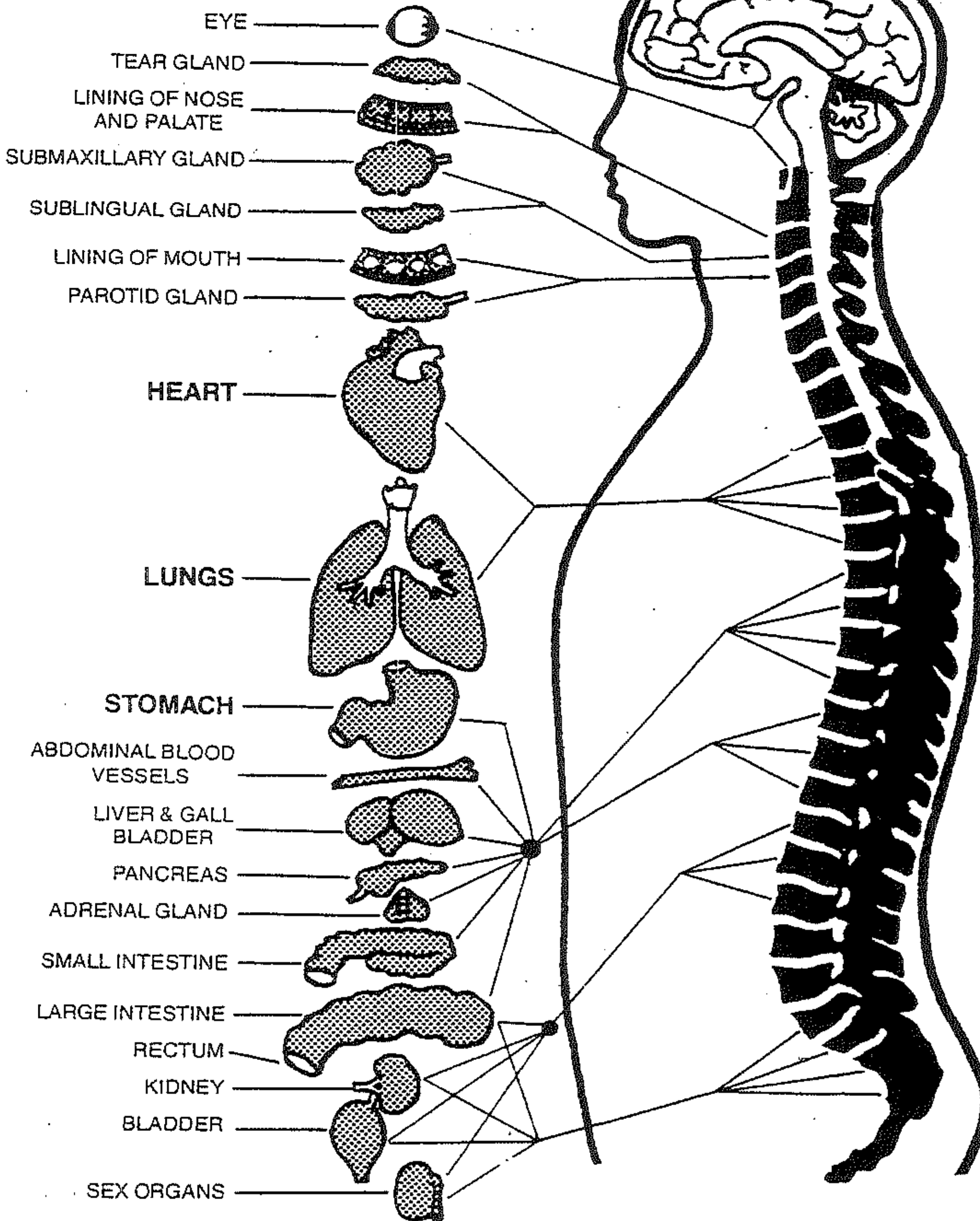
<u>Mark the areas on your body where you feel the described sensations. Please use the appropriate symbol. Mark areas of radiation with arrows.</u>



Name ______________________ Date ________________

CHIROPRACTIC HEALTH QUESTIONNAIRE

Please circle area of pain or malfunction on diagram



Are you now or have you suffered from any of the following. Check appropriate box.

Past	Present	No	
			Eye disorders
			Loss of Taste
			Headaches
			Nervousness
			Trouble Sleeping
			Dizziness
			Loss of Smell
			Sinus Trouble
			Ear Disorders
			Frequent Sore Throats
			Asthma
			Hay Fever/Allergies
			Persistant Cough
			Stomach Problems
			Rheumatic Fever
			Tuberculosis
			Heart Disease
			High Blood Pressure
			Diabetes
			Poor Digestion
			Nausea
			Vomiting
			Constipation
			Diarrhea
			Abdominal Pain
			Hemorroids
			Urinary Disorders
			Bed Wetting
			Menstrual Disorders
			Sex Problems
			Tension
			Irritability
			Fatigue
			Sleeping Problems

Symptoms related to the Autonomic Nervous System

Chiropractic deals with the relationship between your spine and nervous system

The Nervous System's function is to control and co-ordinate all the other organs and structures. Pinched or irritated nerves may interfere with this function and thus cause a wide variety of symptoms.

Name

Date

If you have been in an accident (automobile or otherwise), you should consult with an attorney.

Kent-East Chiropractic can refer you to one of several attorneys' who will consult with you about your care at no charge or obligation.

It is important to me that my patients know their legal rights about their accident cases.

KENT EAST CHIROPRACTIC

ALLAN R. McCORD

PERSONAL INJURY PROTECTION

What Is PIP?

Personal Injury Protection is part of your auto insurance policy. It is designed to take care of you immediately after an accident.

ALWAYS USE YOUR PIP!

- ☆ **PIP** covers medical bills, a portion of your weekly lost wages, and for household care and cleaning.
- ☆ Your insurance company, by law, **cannot cancel your policy** for using your **PIP**.
- ☆ If you have not rejected **PIP** coverage in writing, then you are deemed to have it.
- ☆ Your insurance company, by law, **cannot increase your insurance rates** for using your **PIP**.
- ☆ Open up your **PIP** claim immediately! If you wait you may find yourself paying for expensive medical bills out of your pocket until your claim is settled.
- ☆ **PIP** is no-fault, so it doesn't matter who caused the accident, you're still covered.
- ☆ **PIP** coverage is for 3 years or $10,000, which ever comes first. Some policies have higher limits.
- ☆ There is no deductible.
- ☆ If you have coverage on your auto policy, your medical bills get paid on time and you can maintain your treatment schedule uninterrupted.

What Is Med Pay?

Med Pay is a medical payments only version of **PIP**. It does not cover wage loss or loss of services.

Attorneys at Law

March 2004

A Step-By-Step Guide:

- ☑ Call your insurance agent.
- ☑ Ask if you have PIP or Med Pay. If yes, ask about limits on time and dollar amount (3 years/$10,000.)
- ☑ Ask your agent to take your Report of Loss claim.
- ☑ Ask your agent to phone in your report to the claims office.
- ☑ Ask your agent to call back with the claim number, address and phone number of the claims office.
- ☑ Call the claims office and get the name of the claims adjuster handling your claim.
- ☑ Ask the claims adjuster to mail a PIP Application, Attending Physician's Report and Salary Verification forms.
- ☑ Complete the PIP Application and return it to the claims adjuster.
- ☑ Have your doctor fill out the Attending Physician's Report form and return it to you. Mail it to the claims adjuster.
- ☑ Have your employer complete the Salary Verification form and return it to you. Mail it to the claims adjuster.
- ☑ Provide your claim number and the adjuster's name, office address and phone number to all your Health Care Providers.
- ☑ Instruct your Health Care Providers to bill your PIP carrier directly, including copies of chart notes for each day of service.

Local Offices:

We're in your neighborhood!

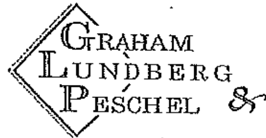
Auburn
Bellevue
Burien
Everett
Federal Way
Gig Harbor
Lakewood
Lynnwood
Marysville
Olympia
Port Orchard
Puyallup
Renton
Seattle
Tacoma

Don't Panic!

Call us for a free consultation.

North Puget Sound area including King & Snohomish Counties
(800) 422-4610

South Puget Sound including Pierce, Kitsap & Thurston Counties
(800) 273-5005



Attorneys at Law

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