LOFT CHIROPRACTIC

Today's Date _____
Referred by _____

AUTO ACCIDENT QUESTIONNAIRE

All questions must be answered completely

Last Name _____ First _____ MI _____
Address _____ Phone _____
_____ Mobile _____
Social Security # _____ Email _____
Date of Birth _____

Employer _____ Occupation _____
Address _____ ___ Full time ___ Part time
_____ Phone _____

INSURANCE INFORMATION

Insurance Company _____ Claim #_____
Address _____ Policy # _____
_____ File # _____

Policy Holder _____ Relationship to you _____

Adjuster Name _____
Adjuster Phone # _____
Adjuster Fax # _____
Adjuster Email _____

Date of Accident _____ Time of Accident _____
Location of Accident _____
___ Yes ___ No Were police notified?
___ Yes ___ No Was an accident report taken?
Responding Police Department _____
___ Yes ___ No Was the accident reported to your insurance company?
___ Yes ___ No Was an "Application of No-Fault Benefits" filed with your insurance company?
If **yes**, when was it filed? _____
If **no**, please notify our office immediately

ATTORNEY INFORMATION

Attorney Name _____ Phone _____
Name of Law Firm _____ Fax _____
Law Firm Address _____ Email _____
_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for No-Fault benefits is denied. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Patient Signature _____ Date _____

Name _____ **Date** _____

AUTO ACCIDENT INFORMATION

Date/Time of Accident _____
In the hours and days following the accident, how did you feel?_____
_____
When did you first notice any symptoms? _____
Since the accident are your symptoms: ___ Improving ___Getting worse ___ Staying the same
Have you ever had these symptoms before? ____ Yes ___ No
If **yes**, explain _____
Was anyone in the vehicle with you? ____ Yes ___ No
If **yes**, who? _____
Have you missed time from work since the accident? ____ Yes ___ No
If **yes**, how much? _____
Where did accident take place? _____
Your vehicle make and model _____
OTHER vehicle make and model _____
What was your vehicle doing at the time of the accident?
___ Stopped at intersection ___ Turning left ___ Turning right ___ Stopped at light
___ Parking ___ Stopped in traffic ___ Maintaining speed ___ Accelerating
___ Other _____

What was the visibility at the time of the accident?
___ Good ___ Fair ___ Poor
What were the road conditions?
___ Icy ___ Wet ___ Sandy ___ Rocky ___ Clear/Dry

What was your position in the vehicle?
___ Driver ___ Passenger ___ Back seat
What was your speed? _____
What was their speed? _____

Did you hit the other vehicle? ____ Yes ___ No
Did the other vehicle hit you? ____ Yes ___ No
Which hands were on the steering wheel?
___ Right ___ Left ___ Both ___ Neither

Did you brace for impact? ____ Yes ___ No
*If **yes**, what did you use?* ___Hands ___Feet ___Both
Did your body hit inside the vehicle? ____ Yes ___ No
*If **yes**, what hit where?* _____

Did you see the accident coming? ____ Yes ___ No
Were you wearing a seat belt? ____ Yes ___ No
Did the seat bend or break? ____ Yes ___ No
Did Airbags deploy? ____ Yes ___ No
___ Driver ___ Passenger ___ Side ___ Other

Did you lose consciousness? ____ Yes ___ No
If **yes**, for how long? _____

What was the damage to your vehicle?
___ None ___ Mild ___ Moderate ___ Totaled
What was the damage to the other vehicle?
___ None ___ Mild ___ Moderate ___ Totaled
What direction was your head facing?
___ Forward ___ Right ___ Left

What was the point of impact?
___ Head on ___ Right side ___ Right front ___ Right rear
___ Back end ___ Left side ___ Right front ___ Left rear
Was there another collision?____ Yes ___ No
___ Head on ___ Right side ___ Right front ___ Right rear
___ Back end ___ Left side ___ Right front ___ Left rear

What was the position of your headrest at the time of the accident?
___ No headrest ___ Even w/top of head ___ Even w/bottom of head ___ Mid-neck

---

Where did you go after the accident? ___ Home ___ Work ___ School ___ Emergency Room
___ Urgent Care ___ Chiropractor ___ Private Dr. ___ Other
How did you get there? ___ Drove self ___ Someone else ___ Ambulance ___ Police ___ Public Transport/Uber/Lyft
Have you gone to the hospital/Urgent Care since the accident? ____ Yes ___ No
How long after the accident? _____
Hospital Name _____
Were you admitted? ____ Yes ___ No If **yes**, for how long? _____
Xrays/MRI/CT Scan done? ____ Yes ___ No If **yes**, what? _____