VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date________________

Patient Name____

Date of Accident____________________ Time of Accident____________________ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:____

____

____

____

Were you the: ☐ Driver ☐ Rear Passenger ☐ Front Passenger ☐ Pedestrian

How many people were in the accident vehicle?________

ACCIDENT SITE

Road/Street Name____________________

City/State____________________

Nearest intersection with road/street____________________

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other ________

Which direction were you headed? ____________________

Speed you were traveling?____________________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest?
☐ Low ☐ Midposition ☐ High

OTHER VEHICLE
(if applicable)

Make and model of other vehicle____________________

Which direction was other vehicle headed?____________________

Speed other vehicle was traveling____________________

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No
If yes, explain____________________

____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain____________________

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other__________

At the time of impact were you:
☐ Looking straight ahead
☐ Looking to the left
☐ Looking up
☐ Looking to the right
☐ Looking down

Were both hands on the steering wheel? ☐ Yes ☐ No
If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No
If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom?____________________

(Vers.C2SSS04)

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?____________________

Please describe how you felt immediately after the accident:

____

____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital__________________________ Name of doctor__________________________

Diagnosis____

____

Treatment received____

X-rays taken____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?____________

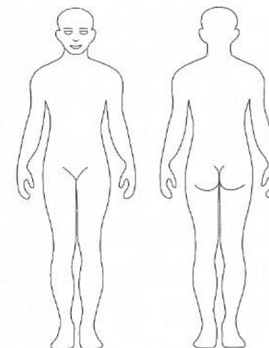
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other____________

How often do you have this pain?____________________________________

Is it constant or does it come and go?________________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ____________________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

ASSIGNMENT

Patient:

Doctor:
Butler-Townsend Chiropractic
3104 S. Lakeport St.
Sioux City, IA 51106

For good and valuable consideration, the undersigned patient hereby assigns Butler-Townsend Chiropractic from any and all moneys or proceeds realized from any settlement, verdict or judgment in my favor for injuries and damages arising out of a motor vehicle accident which occurred on the ______ day of _______, ______, so much of those moneys and proceeds as is necessary to pay and satisfy, in full, any sums due and owing by me to Butler-Townsend Chiropractic for services rendered.

Butler-Townsend Chiropractic is hereby authorized to furnish copies of this Assignment to any representative, including attorney, who may be assisting me with respect to the above referenced motor vehicle accident and any such representative is hereby irrevocably authorized to acknowledge, in writing, receipt of this Assignment and honor said assignment and pay to Butler-Townsend Chiropractic those sums due and owing it under the terms hereof from said settlement, verdict or judgment before any proceeds are paid to me.

Butler-Townsend Chiropractic is further authorized to furnish copies of this Assignment to any insurance company responsible for paying any portion of any claim made by me, or on my behalf, for injuries and damages, including medical expense payments, suffered by me arising out of the above referenced motor vehicle accident. Any such insurance company, if requested, shall acknowledge, in writing, receipt of this Assignment and honor said Assignment and pay to Butler-Townsend Chiropractic those sums due by me for chiropractic services.

I fully understand that I am completely responsible for any unpaid sums due and owing Butler-Townsend Chiropractic for services rendered to me, or on my behalf, and that this Assignment in no way is intended nor should it be construed to relieve me from any personal responsibility for such service to the extent not otherwise paid for by my representative and, or, any such insurance company. I further understand that I am personally responsible for services rendered by Butler-Townsend Chiropractic and that my responsibility is not contingent upon the outcome of any claim made by me, or on my behalf, and that I will remain fully responsible for payment of said services irrespective of the outcome of any such claim. Payment will be due and payable within 30 days after release from care by doctor, or discontinuation of care by patient.

______________________ ______________________________
Date Patient

RECEIPT OF ASSIGNMENT

THE UNDERSIGNED attorney/insurance company hereby acknowledges receipt of a copy of this Assignment and agrees to honor said Assignment in accordance with the terms thereof.

______________________ ______________________________
Date Representative/Insurance Company

By______________________________
Print Name