BIONIC Chiropractic
108 E. Arctic Ave.
Palmer, AK 99645

Joseph T. Hawkins, D.C.
PH: (907)745-4357
Fax: (907)745-4606

Auto Accident Introduction Form

Patient Name: _____ Home Phone_____
(First) (MI) (Last)
Cell Phone:_____ Appointment Text Reminder ____Yes ____No Cell Phone Carrier _____

Birthdate:_____ Age:_____ Social Security # ____-____-_____ Driver's Lic. No._____

Mailing address: _____
(Address) (City) (State) (Zip)
Physical Address: _____
(Address) (City) (State) (Zip)
Male____Female____Marital Status M____ S____W____D____SEP____ Spouse's Name: _____
Employer: _____Occupation _____
Work Address: _____ Work Phone: (____)_____

How did you hear about us? Sign_____ Newspaper_____ Phone Book_____ Other_____

Accident Description

Date of Accident: _____ Hour: _____ AM____PM____Location: _____

- *Describe the Accident*:_____
_____
_____
Described what happened to you upon impact:_____
_____

Type of collision ____Head-on ____Broad side ____Rear-end ____Front impact____Non-collision
You were the ____Driver ____Passenger ____Pedestrian
You were struck from ____Behind ____Front ____Rt. Side ____Lt. Side
Visibility at time of accident: ____Poor ____Fair ____Good ____Other:_____
Road conditions:____Icy ____Rainy/Wet ____Clear ____Dark ____Other:_____
Did other car(s) strike your car ____Yes ____No ____N/A
Did your car strike other car(s) ____Yes ____No ____N/A
Head position at time of impact?____Looking straight ahead ____Right ____Left
Did you see the accident coming? ____Yes ____No Did you brace for impact? ____Yes ____No
Were seatbelts worn? ____Yes ____No Does the car have headrests? ____Yes ____No
At the time of impact, top of HEADRESTS were *even* with:
____ BOTTOM of head ____ TOP of head ____ MIDDLE of neck
Was your car braking? ____Yes ____No Was your car moving at the time of impact? ____Yes ____No
Estimate YOUR speed: _____mph Estimate the OTHER CAR'S speed: _____mph
Year and model of your car: _____ Approximate damage $_____

*This office will bill <u>all</u> P.I. claims as first party claims (meaning the patient's personal car insurance) without exception, and regardless of fault. If there is no med-pay on the first party policy we will as a courtesy bill third party provided a $50 non-refundable fee is rendered at the beginning of treatment to cover the legal costs of recording and releasing medical liens.

- *Insurance Company's Name*: _____ Policy #_____
Claim # _____Phone # (_____)_____ Adjusters Name: _____
Address: _____
(Address) (City) (State) (Zip)

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Auto Accident Introduction Form, *continued*

- *Did you seek medical help immediately or soon after the accident?* ____Yes ____No
  If yes, how did you get there? ____ someone else drove me
  ____ ambulance
  ____ drove own car
  ____ police
  ____ other _____

  Doctor/Hospital/Clinic: _____ Date seen:_____
  Were you examined? ____ Yes ____No
  Were X-rays taken? ____ Yes ____No
  Were you given treatment? ____Yes ____No
  What treatment was given to you?_____
  What benefits did you receive from the treatment? _____
  _____Date of last treatment_____

- *Do you have an attorney?* ____Yes ____No Attorney's name_____
  Address_____ Phone number (____)_____

Subjective Complaints

- *Describe complaints*:
  Involving NECK & HEAD_____
  Involving MID-BACK/SHOULDERS/ARMS & HANDS _____
  Involving LOW-BACK/HIPS/LEGS/FEET_____

- *What activities make the condition WORSE*? _____
  _____
  What activities make the condition BETTER? _____
  _____

- *Indicate ability to perform the following activities*:
  USE CODES: *P*-PAINFUL *D*-DIFFICULT *N*-NORMAL

____coughing/sneezing	____climbing
____getting in or out of a car	____kneeling
____bending forward to brush teeth	____balancing
____turning over in bed	____dressing self
____walking short distance	____sleeping
____standing for more than an hour	____stooping
____sitting at a table	____gripping
____lying on back	____pushing
____lying flat on stomach	____pulling
____lying on side with knees bent	____reaching
____bending over forward	____sexual activity

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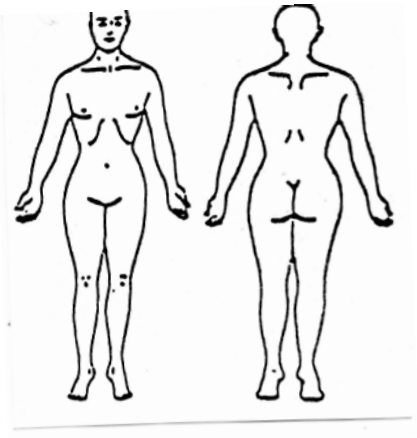
Auto Accident Introduction Form, *continued*

- *Check symptoms you have noticed since the accident*:

____blurring vision	____shortness of breath	____chest pain	____loss of smell
____confusion	____nervousness	____depression	____loss of taste
____convulsions	____eyes sensitive to light	____irritability	____loss of balance
____crying spells	____pain behind eyes	____cold sweats	____fainting
____paralysis	____headaches	____stomach upset	____anxious
____muscle jerking	____neck pain	____diarrhea	____sleeping problems
____numbness	____neck stiff	____feet cold	____numbness in toes
____dizziness	____mid back pain	____hands cold	____face flushed
____head seems too heavy	____low back pain	____constipation	____numbness in fingers
____pins/needles in arms	____leg pain	____memory loss	____fatigue
____pins/needles in legs	____tension	____ears ringing	____ears buzzing

____other_____

Shade and label area(s) to indicate location of pain or discomfort. Use codes: P – *pain*
N – *numbness*
S – *spasm*
T – *tenderness*



Symptoms are *better* in ____AM ____Midday ____PM
Symptoms are *worse* in ____AM ____Midday ____PM
__ Symptoms do not change with the time of day

Women only: Is there any chance you may be pregnant? ____Yes ____No

Patient Agreement

I certify that the information obtained in this form is true and correct to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me and that I am personally responsible for services rendered. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I understand that information concerning my accident/injury claim can be requested by my insurance company. Also, records from any past/present care you have given me can be requested. By signing below I/we authorize BIONIC Chiropractic to send any requested records and/or x-rays.

Signature of Patient/Guardian _____ Date _____