BACK 2 BACK
CHIROPRACTIC

ATTENTION !!!

The "Auto Accident Questionaire" form is an interactive form. (*Interactive means that you may type in your information.*) However, you can still print the form and fill in the requested information in pen and ink.

If you wish to utilize this interactive form by typing in the requested information, you must follow the instructions below in order to protect the privacy of your information:

1. Save the form to your computer and remember where you save it.
2. Close out your internet browser.
3. You can now open the form in Adobe Acrobat Reader and fill in all the requested information.
4. Please do not close the form before you PRINT it or all your information will lost.

The data that you input to this form cannot be saved and a warning will appear informing you.

Thank You

Continue

BACK2BACK CHIROPRACTIC

AUTO ACCIDENT QUESTIONAIRE

Print Form

4124 Walney Road, Suite N, Chantilly, VA 20151, **Phone:** 703-378-8633 **Fax:** 703-378-7388
12847 Braemar Village Plaza, Bristow, VA 20136, **Phone:** 703-365-8333, **Fax:** 703-365-0448

PATIENT INFORMATION

Date: _____

Patients Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

eMail Address: _____

Sex: _____ Age: _____ Birth Date: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patients SSN: _____

Occupation: _____

Employer: _____

PHONE NUMBERS

Home: _____ Work: _____

Cell Phone: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home: _____ Work: _____

Cell Phone: _____

Who may we thank for referring you? _____

Spouse's Name: _____ Spouse's Occupation: _____

Birth Date: _____ SSN: _____ Spouse's Employer: _____

INSURANCE INFORMATION

Your Auto Insurance Information:

Company: _____ Representative: _____

Phone: _____ Claim No. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Your Other Person's Auto Insurance Information:

Company: _____ Representative: _____

Phone: _____ Claim No. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Your Health Insurance Information:

Company: _____ Representative: _____

Phone: _____ Claim No. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Lawyer's Information:

Name: _____ Phone: _____

ACCIDENT INFORMATION

Date &Time of Accident *(indicate AM or PM)*: _____ Select the State where the accident occurred. -> _____

What was your position in the vehicle? _____ What speed were you traveling at the time of the accident? _____ mph

Who hit who? (i.e. car, stationary object, etc.) _____

What was your vehicles point of impact? _____ What speed was the other vehicle traveling? _____ mph

What was the other vehicles point of impact? _____ Were you prepared for the impact? _____

Were you wearing seat restraints? _____ If yes, What Type? _____

What position were the headrests in? _____ Did the air bags deploy? _____

What position was your body in immediately prior to impact? _____

What happened to your body at the moment of impact? _____

What was your mental/emotional status immediately following the accident? _____

Did your receive any medical attention at the scene of the accident? _____

Where did you go immediately following the accident? _____

What position was your body in immediately prior to impact? _____

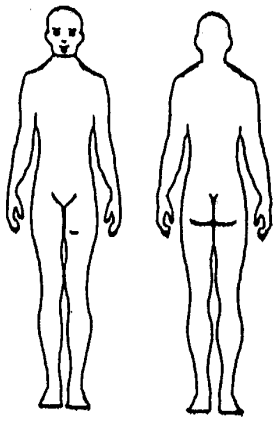
PATIENT CONDITION

Patients Name: _____

When did your symptoms appear? _____

Is the condition getting progressively worse? _____

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? _____

Does it interfere with (*check all that apply*): ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

PAST HISTORY

Have you ever injured this area before? _____ If yes, when and what happened? _____

Have you been involved in any previous accidents of any kind *(personal injury, automobile, workers' compensation, etc.)*? _____

If yes, please explain dates and details. _____

Have you ever previously been treated by a chiropractor? _____

If yes, please explain. _____

Have you enjoyed good health prior to this accident? _____

If no, please explain *(i.e. illness or injuries)* _____

PRESENT INFORMATION/DISABILITY

Have you returned to work? _____ If yes, date returned to work.: _____

Please describe your job. _____

Do you notice any activity restrictions as a result of this accident? _____

If yes, please explain. _____

Since this injury are your symptoms?: _____

Please explain the symptom(s).: _____

What doctors have you consulted for this accident? *(Please list)* _____

What was the doctors' diagnosis? _____

What treatment have you received? _____

Are you still under a doctor's care? _____

If yes, please explain. _____

ASSIGNMENT, RELEASE AND FINANCIAL AGREEMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with the above insurance carrier and assign directly to Back 2 Back Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Further to the best of my knowledge the information provided to this office is complete and accurate. I acknowledge that ALL charges incurred in this office are my responsibility. Should my insurance, for any reason, fail to pay for all charges billed, I agree to pay for services upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of thirty (30) days, unless prior arrangements have been made, it may be referred to an agency or an attorney for collection. I understand that should my account be placed for collection, then I agree to be responsible and pay for all costs incurred including 35% attorney's fees ($100.00 minimum) and interest at 2% per month (24% per annum).

_____ _____

Signature Date