

**Renaissance Chiropractic Center**  
4902 Tacoma Mall Blvd. Tacoma, WA 9840 (253) 473-0300

**Automobile Collision Questionnaire**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of accident: \_\_\_\_\_

**PLEASE WRITE A DETAILED DESCRIPTION OF THE ACCIDENT:**

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**Is this incident work related ? \_\_\_\_\_ Auto Accident ? \_\_\_\_\_**

If auto accident, were you:  driver  passenger  pedestrian

Location: City \_\_\_\_\_ State \_\_\_\_\_ Street(s) \_\_\_\_\_

Road Conditions:  [Dry]  [Wet]  [Icy] Other: \_\_\_\_\_

**What kind of vehicle were you in:** \_\_\_\_\_

What type of transmission in your vehicle:  Automatic  Manual (stick-shift)

Were you aware of the impending collision or were you surprised?  Aware  Surprised

If auto collision, were you struck from:  behind  right side  left side  front

Did the other car strike yours?  yes  no Did your car strike the others involved?  yes  no

Were there multiple impacts:  yes  no If yes, how many \_\_\_\_\_

Was your foot on the brake?  yes  no were you wearing your seatbelt?  yes  no

Did any Airbags deploy?  yes  no  front  side curtain

At the impact was your head facing:  forward  to the right  to the left  other: \_\_\_\_\_

How was the headrest positioned for your head?  high  low  middle  no head rest

After the collision, what direction was your vehicle facing:  same  to the right  to the left

facing the opposite direction  not sure  other: \_\_\_\_\_

**What was the other vehicle?** \_\_\_\_\_

Was there more than one other vehicle involved:  yes  no how many? \_\_\_\_\_

What kind: \_\_\_\_\_

Did the impact cause you to lose your glasses or hat?  yes  no

Did you hit any part of the body on anything inside the vehicle?  no  yes, what? \_\_\_\_\_

Did you lose consciousness?  yes  no Were you treated by the Paramedics at the scene?  yes  no

Were you taken by ambulance to the hospital emergency room?  yes  no

Did you have x-rays taken?  yes  no what regions? \_\_\_\_\_

Were you given any medications?  yes  no what? \_\_\_\_\_

Condition since Accident:  [Worsened]  [Improved]  [Stayed the same]

**PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Neck Stiffness   | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ringing       | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Upper Back Pain  | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed       | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Lower Back Pain  | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Loss of Smell      | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability     | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> _____         |
| <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Depression               | <input type="checkbox"/> Sleeping Problems  | <input type="checkbox"/> _____         |

**Patient's Auto Insurance: Do you have Personal Injury Protection (PIP)  Yes  No**

Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Claim #: \_\_\_\_\_ Claim Manager's name: \_\_\_\_\_

**Auto Insurance Company Responsible in Accident:**

Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Name of person responsible for accident: \_\_\_\_\_

Name of insured on this policy: \_\_\_\_\_

Claim #: \_\_\_\_\_ Claim Manager's name: \_\_\_\_\_

**General Health Insurance:**

Ins Co: \_\_\_\_\_ Subscriber: \_\_\_\_\_ ID/Group #: \_\_\_\_\_

**Do you have an attorney involved in this case?**  Yes  No

If so, attorney's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

\*In the event there is no attorney involvement, I authorize Renaissance Chiropractic Center to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with this filing.

**I hereby understand that interest will be charged on any unpaid balance due on my account commencing on the first day of my being released from active/scheduled treatment. Interest on my account shall be at the rate of twelve percent (12%) per annum on the balance owed by me and will be calculated half-yearly from date of my release from active/scheduled treatment and every six (6) months thereafter.**

**Patient's Signature:** \_\_\_\_\_

**Parent/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_