

MORRISON CHIROPRACTIC, P.A.

Gentle, Effective, Quality Chiropractic Care

PERSONAL INJURY

AUTO/ATTORNEY INFORMATION

Patient Name: _____ Date of Accident: _____

Patient's Policy: _____

Insured's Name: _____

Has PIP Been: _____ Filed? _____ Exhausted? _____ Waived?

Date: _____

Insurance Carrier: _____

Claim #: _____ Adjustor: _____ Phone #: _____

Claim Address: _____

Attorney Name: _____ Phone : _____

Address: _____

FOR OFFICE USE ONLY

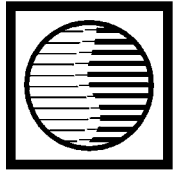
Initial Report Date: _____ Mailed: _____

Interim Reports Date: _____ Mailed: _____

Discharge Date: _____ Final Report Date: _____ Final Bill Date: _____

_____ Assignment of Benefits/Lien Signed by Patient/Attorney

Notes:



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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Name: _____

Date/Time of Accident: _____

Please explain in detail how the accident happened: _____

Where did you feel pain immediately after the accident?: _____

List the extent of your injuries as you know them: _____

Check the Symptoms that you have noticed since the accident:

- | | | | |
|----------------------------------------------|----------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Feels Too Heavy | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Tension | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Shortness of Breath | Other: _____ | | |

Were you wearing a seatbelt/shoulder harness? Yes No

Did Airbag deploy? Yes No

Did you strike your head on any part of the vehicle? Yes No

Did you lose consciousness? Yes No

Was your head turned left or right at impact? Yes No

Was your car: Stopped Rolling Moving with traffic?

Was your foot on the brake? Yes No

Where were you taken after the accident? _____

How were you taken there? Ambulance Drove Self Driven by Someone

Were you Hospitalized? Yes No

If yes, How long were you admitted? _____

Name of Hospital/Doctor? _____

What Treatment was given? _____

Was any other doctor consulted? If yes, Who? _____

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area? Yes No

If so, what was the complaint? _____

Are your work/daily activities restricted as a result of the accident? Yes No

Since your injury are your symptoms Improving Getting Worse Staying the Same

Signature: _____ Date: _____