**BASTRON CHIROPRACTIC INC.**
**1010 S. 336TH ST. SUITE 120**
**FEDERAL WAY, WA. 98003**

## AUTOMOBILE COLLISION QUESTIONNAIRE

**General Information:**
Name_____ Phone Number_____
Address_____ City_____ State____ Zip_____

**Nature of Collision:**
1. Date of Collision?_____ 20_____ Time:_____ AM PM
2. Where did the collision occur? City/Town:_____ State_____
3. Please describe in detail how your collision occurred?

_____
_____
_____
_____

4. Were you the: ❑driver ❑passenger ❑pedestrian
5. If passenger, were you in the: ❑front seat ❑right rear seat ❑left rear seat
6. What type of vehicle were you in? _____
7. What type was the other vehicle? _____
8. Did your vehicle strike the other vehicle? ❑yes ❑no
9. Was your car struck by the other vehicle? ❑yes ❑no
10. Was the impact from: ❑the front ❑the rear ❑the left side ❑the right side
11. What was the approximate speed at the time of the impact?
    Your vehicle _____mph Other vehicle _____mph
12. How much damage was done to **your** vehicle $_____
    The other vehicle $_____ ❑Not Sure
13. What was the weather at the time of the collision? ❑dry ❑wet ❑icy
14. Was your vehicle in: ❑park ❑neutral ❑in gear ❑moving ❑stopped
15. Were your brakes being applied? ❑yes ❑no
16. Was your vehicle shoved: ❑forward ❑backward ❑sideways
17. Were you shoved: ❑forward ❑whipped backward ❑sideways
18. Did your seat have a head restraint (headrest?) ❑yes ❑no
19. If yes, what was the position? ❑low ❑mid-position ❑high
20. Did your head ride over the headrest? ❑yes ❑no
22. Did any other part of your body hit the interior of the vehicle? ❑yes ❑no

23. If yes, please specify: ❑seatbelt restraints ❑steering wheel ❑dashboard ❑windshield ❑side door ❑side window ❑Other
24. Which part of your body? ❑chest ❑head ❑chin ❑face ❑R L knee ❑R L shoulder ❑R L hand ❑Other
25. Were you holding on to the steering wheel? ❑yes ❑no
26. Did you brace your arms against the dash? ❑yes ❑no
27. Did you brace your legs against the floorboard? ❑yes ❑no
28. Was your ankle turned? ❑yes ❑no
29. Did the vehicle go into a spin or roll as a result of the impact? ❑yes ❑no
30. If yes, explain:_____
31. At the point of impact, where did you experience pain? Be specific: _____
_____
_____
_____
32. Immediately after the accident were you: ❑conscious ❑dazed ❑unconscious
33. What is the next thing you remember immediately after the impact?_____
_____
34. If you lost consciousness, how long? _____
35. Were you wearing a seat belt? ❑yes ❑no
36. Did the belt have a shoulder harness? ❑yes ❑no
39. If yes, did it contribute to the pain you are experiencing? ❑yes ❑no
40. At the time of impact were you: ❑looking straight ahead ❑looking to the right ❑looking to the left ❑looking down ❑looking up
41. Did the seat break as a result of the impact? ❑yes ❑no
42. Were you braced for the impact? ❑yes ❑no
43. Were you surprised by the impact? ❑yes ❑no
44. Did you go to the hospital? ❑yes ❑no
45. If yes, when? ❑right after the accident ❑next day ❑other: _____
46. If yes, how did you get there? ❑ambulance ❑other:
47. If by ambulance, did the ambulance attendants place you in a: ❑neck brace ❑back brace ❑other: _____
48. Any medication or medical supplies given? _____
49. Did you have x-rays taken at the hospital? ❑yes ❑no

50. If you went to the hospital, please answer the following: Name of Doctor: _____

Diagnosis _____

Treatment Received _____

51. Did you consult any other doctors prior to coming to this office? ❑yes ❑no

52. If yes, who and type of doctor/therapist? _____

_____

53. What treatment did you receive? _____

54. Did the treatment help? _____

55. Describe the doctor's diagnosis?_____

56. Are you still under a doctor's care? ❑yes ❑no If yes, please explain: _____

_____

57. If no, when were you last treated? _____

**Past History:**

1. Have you ever injured this area before? ❑yes ❑no If yes, when? _____

2. Have you been involved in any previous accidents of any kind (personal injury, automobile collision or worker's compensation)? ❑yes ❑no If yes, please explain dates and details

_____

_____

_____

3. Have you enjoyed good health prior to this accident?❑yes ❑no If no, please explain:

**Present Information/Disability:**

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

2. Job description _____

3. Are your work activities restricted as a result of this accident? _____, If yes, please explain:

_____

_____

4. Do you notice any activity restrictions as a result of this injury? _____, If yes, please describe:_____

_____

5. Since this injury are your symptoms: ❑improving ❑getting worse ❑staying the same Please explain: _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____ Date_____

Witness_____ Date_____

**PERSONAL INJURY INSURANCE QUESTIONAIRE**

**Please Complete <u>All</u> Blanks – <u>All</u> Information Is Required**

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**YOUR INSURANCE COMPANY INFORMATION**

Insurance Company Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Claims Adjuster: _____
Claim #: _____
Policy #: _____

**Do you have PIP (personal injury protection)?** ❑ Yes ❑ No

If yes, are you the insured? ❑ Yes ❑ No

Limit? ❑ $10,000 ❑ $35,000 ❑ Other ❑ Not Sure

If no, Insured's Name: _____ Phone #: _____
Insured's Address: _____

**Date of Accident**: _____

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**AT FAULT PARTIES PERSONAL INFORMATION** – (The driver of the other vehicle)

At Fault Driver's Name: _____
At Fault Driver's Address: _____
City, State, Zip: _____

**AT FAULT PERSON'S INSURANCE INFORMATION**

At Fault Driver's Insurance Company: _____
Insurance Company Address: _____
City, State, Zip: _____
Insurance Company Phone #: _____ Claim #: _____
Claims Adjuster Name: _____ Policy #: _____

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**ATTORNEY INFORMATION**
Have you retained an Attorney? ❑Yes ❑No
Attorney Name: _____
Attorney Phone #: _____
Attorney Address: _____
City, State, Zip: _____