Automobile Accident Paperwork

It is important that each section of our Auto Accident forms are fully completed. All the information provided here is used to generate an insurance report that is required to be sent to your Insurance company. Any questions that are not answered will result in a delay of your information and invoices being sent to your insurance company for reimbursement.

Personal Information:

First name: ______________________________ Last name: ________________________________

Address: ____

City: ___________________________ State: __________ Zip: _____________________________

e-mail: ____

Home phone: _______________________________ Cell phone: _____________________________

Date of Birth: _______________________________ Dominant hand: Right Left

Date of Injury: ______________________________

Please describe accident in detail:

____

____

____

____

____

184 Mammoth Rd Unit 6
Londonderry, NH 03053
phone 603-434-8300   fax 603-965-1057

Auto Accident Billing Policy

All billing from our office, pertaining to your auto accident will be sent to your Insurance Company that you have listed below, for processing. Per New Hampshire State law (RSA 264:16), checks are mailed directly to you, the policyholder and **not** sent to our office.

Due to the NH state law, our office policy requires patients to pay for the services rendered at the time of your visit. This ensures that your account is paid and up to date.

In NH, when you are involved in an auto accident, you must open a Med-pay Claim with your own insurance company. The state of NH requires your insurance company to collect funds from the at-fault insurance company. We must bill to your insurance company for services rendered.

Claim number: ______________________

Insurance company: ______________________

Date of Accident: ______________________

Parent Chiropractic Center
J. Daniel Parent, D.C.
Tax ID # 02-0478056

______________________ ______________________

Patient Signature **Date**

______________________ ______________________

Parent/Guardian signature **Date**
(if patient under 18 years of age)

Auto Accident Information sheet

Patient Name: ____

Date of Accident: ____

Insurance Company Information:

Patient Auto Insurance Company Name: ______________________________
(NOT the at fault insurance co.)

Auto Insurance **Billing** Address: ______________________________

City / state / zip______________________________________

Telephone # of Auto Insurance Company:______________________________

Auto Insurance Claim Number: ____________________(not your policy number)

Auto Insurance Adjuster Name: ______________________________________

Adjuster Telephone Number (ext.): ______________________________

Adjuster Fax Number: ______________________________________

Med Pay Amount: $____________________

Any additional info: ____

Important to note: In the state of NH, you **MUST** open a claim with **YOUR** insurance company, we must bill to your insurance company. If you are not at fault, the insurance company will seek funds from the at-fault party's insurance company.

Accident Details: Please answer the questions below. This section pertains to you and the accident. If a questions is not applicable, please write NA.

Your Vehicle Type:
O Car O S.U.V. O Van O Bus
O Large Truck O Pickup Truck

Other Type:______________

Your Position in Vehicle
O Driver O Front Passenger
O L.Rear Passenger O R.Rear Passenger

Other Position:______________

Time/Speed/Damage
Time of Accident: Your Speed
Their Speed

Damage to your vehicle:
O Mild O Moderate
O Totaled

Year, make and model of vehicle

____

What was your vehicle doing at time of accident?
O Stopped at intersection O Stopped in traffic O Stopped at a light
O Making a right turn O Making a left turn O Parking
O Proceeding along O Slowing down O Accelerating

Other:______________________________

Details of Accident:

Visibility at the time:
O Good O Fair O Poor

Road Conditions at Time of Accident:
O Icy O Wet O Sandy
O Dark O Clean & Dry

Point of Impact:
O Head-On O Rear-End
O Left front O Right front
O Left rear O Right rear

Other:______________

Who hit who/what:
O You hit other vehicle
O Other vehicle hit you
You hit....(Type in object below)

Other:______________

Additional Accident Information:
In the case of a motor vehicle accident, write any additional info here.

During the Accident:

Body Position, etc.
Did you see the accident coming?..... Yes ☐☐ No
Were you braced for the impact?.......Yes ☐☐ No
Did you have a seat belt on?............Yes ☐☐ No
Did you have a shoulder harness on? Yes ☐☐ No
Did the driver's front air bag deploy?.. Yes ☐☐ No
Did passenger front air bags deploy? Yes ☐☐ No
Did the side air bags deploy?......... Yes ☐☐ No
Does your vehicle have headrests?... Yes ☐☐ No

Headrest Position?
O Even with top of head
O Even with bottom of head
O Even with middle of the neck

What was the direction of the head at the time of impact?
O Facing straight forward O Turned to the right O Turned to the left

Did your body strike the inside of your vehicle?.........Yes ☐☐ No

If Yes, describe:

Did you lose consciousness during the injury?..........Yes ☐☐ No

If Yes, for how long?

Your vehicle's Estimated Damage:

Damage to their vehicle:
O Mild O Moderate O Totaled

Did police show up at the scene? Yes ☐☐ No

Was an accident report filled out? Yes ☐☐ No

If YES, name of **Police Department**

____

Emergency Room?

Where did you go after the accident?
O Home O Work
O Hospital ER O Private doctor

How did you get there?
O Drove Self O Ambulance
O Somebody Else O Police

X-rays done? Yes ☐☐ No

Was lab work done? Yes ☐☐ No

Body parts X-rayed?

What lab work?

The x-rays revealed..

Treatments: ☐ Cervical Collar ☐ Ice Other

Medications:

Follow-up Instructions:

Name of Hospital, Urgent Care:

____

After the Accident:
Check off the symptoms right after and a few days following the accident.

☐ Headache ☐ Loss of smell ☐ Tension ☐ Loss of taste ☐ Diarrhea
☐ Neck pain ☐ Dizziness ☐ Irritability ☐ Toe numbness ☐ Depression
☐ Neck stiffness ☐ Nausea ☐ Mid back pain ☐ Constipation ☐ Anxious
☐ Fainting ☐ Confusion ☐ Low back pain ☐ Cold hands ☐ Chest pain
☐ Ringing in ears ☐ Fatigue ☐ Nervousness ☐ Cold Feet
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems

Others:

Description of Symptoms: Please indicate each area of your body that was injured in your accident. Please explain each body part **INDIVIDUALLY.** This information is required for a narrative report required for your insurance company.

FIRST

AREA OF CONCERN:

Step 1:
LOCATION OF PAIN box
choose your FIRST area injured
(choose only ONE area at a time)
L=Left, R=Right, B=Both

Step 2:
TYPES OF PAIN box
check all that apply

Step 3:
PAIN FREQUENCY box
choose one

Step 4:
DOES THIS PAIN RADIATE box
Left Side
Right Side
Both sides

Step 5:
ACTIONS AFFECTING PAIN box
check all that apply

Step 6:
PAIN INTENSITY box
choose one

Step 7:
Go to NEXT page
and repeat Steps 1-6 for
the next body part injured

Location of Pain:

- Headaches LO RO BO
  - Front of Head
  - Top and/or Sides
  - Back of Head
- Jaw.......... LO RO BO
- Eye.......... LO RO BO
- Neck......... LO RO BO
- Uppr. Back.. LO RO BO
- Mid Back.... LO RO BO
- Low Back.... LO RO BO
- Chest......... LO RO BO
- Abdomen.... LO RO BO
- Ribs.......... LO RO BO
- Buttocks.... LO RO BO
- Shoulder..... LO RO BO
- Uppr. Arm... LO RO BO
- Foreman..... LO RO BO
- Hand......... LO RO BO
- Hip............ LO RO BO
- Leg........... LO RO BO
- Foot.......... LO RO BO

Other Locations:

Types of Pain:

- Dull
- Numbing
- Throbbing
- Shooting
- Spasm
- Cutting
- Sharp
- Tingling
- Burning
- Pounding
- Stinging
- Cramping
- Aching
- Constricting

Other Types of Pain:

Does this Pain Radiate?

- Head....... LO RO BO
- Neck...... LO RO BO
- Shoulder...LO RO BO
- Arm..........LO RO BO
- Hand....... LO RO BO
- Hip......... LO RO BO
- Leg......... LO RO BO
- Foot....... LO RO BO

Other Locations:

Actions Affecting Pain
B=Brings on A=Aggravates R=Relieves

	B	A	R
In the A.M.			
In the P.M.			
Bending Fwd			
Bending Back			
Bending Left			
Bending Rt.			
Twisting Left			
Twisting Rt.			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Other Actions:			

Pain Frequency:

- Up to 1/4 of awake time
- 1/4 to 1/2 of awake time
- 1/2 to 3/4 of awake time
- Most all the time

Pain Intensity:

- Doesn't affect daily activities
- Somewhat affects activities
- Seriously affects activities
- Prevents activities

Description of Symptoms: Please indicate each area of your body that was injured in your accident. Please explain each body part **INDIVIDUALLY.** This information is required for a narrative report required for your insurance company.

SECOND

AREA OF CONCERN:

Step 1:
LOCATION OF PAIN box
choose your SECOND area injured
(choose only ONE area at a time)
L=Left, R=Right, B=Both

Step 2:
TYPES OF PAIN box
check all that apply

Step 3:
PAIN FREQUENCY box
choose one

Step 4:
DOES THIS PAIN RADIATE box
Left Side
Right Side
Both sides

Step 5:
ACTIONS AFFECTING PAIN box
check all that apply

Step 6:
PAIN INTENSITY box
choose one

Step 7:
Go to NEXT page
and repeat Steps 1-6 for the next body part injured

Location of Pain:

- ❑ Headaches LO RO BO
  - ○ Front of Head
  - ○ Top and/or Sides
  - ○ Back of Head
- ❑ Jaw.......... LO RO BO
- ❑ Eye.......... LO RO BO
- ❑ Neck......... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest......... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs.......... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand......... LO RO BO
- ❑ Hip............ LO RO BO
- ❑ Leg........... LO RO BO
- ❑ Foot.......... LO RO BO

Other Locations: ____________

Types of Pain:

❑Dull	❑Numbing
❑Throbbing	❑Shooting
❑Spasm	❑Cutting
❑Sharp	❑Tingling
❑Burning	❑Pounding
❑Stinging	❑Cramping
❑Aching	❑Constricting

Other Types of Pain: ____________

Does this Pain Radiate?

- ❑ Head....... LO RO BO
- ❑ Neck...... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm..........LO RO BO
- ❑ Hand....... LO RO BO
- ❑ Hip......... LO RO BO
- ❑ Leg......... LO RO BO
- ❑ Foot....... LO RO BO

Other Locations: ____________

Actions Affecting Pain

B=Brings on A=Aggravates R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
____________	❑	❑	❑
____________	❑	❑	❑
____________	❑	❑	❑
____________	❑	❑	❑

Pain Frequency:

- ○ Up to 1/4 of awake time
- ○ 1/4 to 1/2 of awake time
- ○ 1/2 to 3/4 of awake time
- ○ Most all the time

Pain Intensity:

- ○ Doesn't affect daily activities
- ○ Somewhat affects activities
- ○ Seriously affects activities
- ○ Prevents activities

Description of Symptoms: Please indicate each area of your body that was injured in your accident. Please explain each body part **INDIVIDUALLY.** This information is required for a narrative report required for your insurance company.

THIRD
AREA OF CONCERN:

Step 1:
LOCATION OF PAIN box
choose your THIRD area injured
(choose only ONE area at a time)
L=Left, R=Right, B=Both

Step 2:
TYPES OF PAIN box
check all that apply

Step 3:
PAIN FREQUENCY box
choose one

Step 4:
DOES THIS PAIN RADIATE box
Left Side
Right Side
Both sides

Step 5:
ACTIONS AFFECTING PAIN box
check all that apply

Step 6:
PAIN INTENSITY box
choose one

Step 7:
Go to NEXT page
and repeat Steps 1-6 for the next body part injured

Location of Pain:

- ❑ Headaches LO RO BO
  - O Front of Head
  - O Top and/or Sides
  - O Back of Head
- ❑ Jaw........... LO RO BO
- ❑ Eye........... LO RO BO
- ❑ Neck......... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest......... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs.......... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman...... LO RO BO
- ❑ Hand......... LO RO BO
- ❑ Hip............ LO RO BO
- ❑ Leg........... LO RO BO
- ❑ Foot.......... LO RO BO

Other Locations: ____________

Types of Pain:

❑Dull	❑Numbing
❑Throbbing	❑Shooting
❑Spasm	❑Cutting
❑Sharp	❑Tingling
❑Burning	❑Pounding
❑Stinging	❑Cramping
❑Aching	❑Constricting

Other Types of Pain: ____________

Does this Pain Radiate?

- ❑ Head....... LO RO BO
- ❑ Neck...... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm..........LO RO BO
- ❑ Hand....... LO RO BO
- ❑ Hip......... LO RO BO
- ❑ Leg......... LO RO BO
- ❑ Foot....... LO RO BO

Other Locations: ____________

Actions Affecting Pain
B=Brings on A=Aggravates

R=Relieves	**B**	**A**	**R**
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
____________	❑	❑	❑
____________	❑	❑	❑
____________	❑	❑	❑
____________	❑	❑	❑

Pain Frequency:

- O Up to 1/4 of awake time
- O 1/4 to 1/2 of awake time
- O 1/2 to 3/4 of awake time
- O Most all the time

Pain Intensity:

- O Doesn't affect daily activities
- O Somewhat affects activities
- O Seriously affects activities
- O Prevents activities

Description of Symptoms: Please indicate each area of your body that was injured in your accident. Please explain each body part **INDIVIDUALLY.** This information is required for a narrative report required for your insurance company.

FOURTH

AREA OF CONCERN:

Step 1:
LOCATION OF PAIN box
choose your FOURTH area injured
(choose only ONE area at a time)
L=Left, R=Right, B=Both

Step 2:
TYPES OF PAIN box
check all that apply

Step 3:
PAIN FREQUENCY box
choose one

Step 4:
DOES THIS PAIN RADIATE box
Left Side
Right Side
Both sides

Step 5:
ACTIONS AFFECTING PAIN box
check all that apply

Step 6:
PAIN INTENSITY box
choose one

Step 7:
Go to NEXT page
and repeat Steps 1-6 for the next body part injured

Location of Pain:

- ❑ Headaches LO RO BO
  - O Front of Head
  - O Top and/or Sides
  - O Back of Head
- ❑ Jaw.......... LO RO BO
- ❑ Eye.......... LO RO BO
- ❑ Neck......... LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back.... LO RO BO
- ❑ Low Back.... LO RO BO
- ❑ Chest......... LO RO BO
- ❑ Abdomen.... LO RO BO
- ❑ Ribs.......... LO RO BO
- ❑ Buttocks.... LO RO BO
- ❑ Shoulder..... LO RO BO
- ❑ Uppr. Arm... LO RO BO
- ❑ Foreman..... LO RO BO
- ❑ Hand......... LO RO BO
- ❑ Hip............ LO RO BO
- ❑ Leg........... LO RO BO
- ❑ Foot.......... LO RO BO

Other Locations: ________

Types of Pain:

- ❑Dull
- ❑Numbing
- ❑Throbbing
- ❑Shooting
- ❑Spasm
- ❑Cutting
- ❑Sharp
- ❑Tingling
- ❑Burning
- ❑Pounding
- ❑Stinging
- ❑Cramping
- ❑Aching
- ❑Constricting

Other Types of Pain: ________

Does this Pain Radiate?

- ❑ Head....... LO RO BO
- ❑ Neck...... LO RO BO
- ❑ Shoulder...LO RO BO
- ❑ Arm..........LO RO BO
- ❑ Hand....... LO RO BO
- ❑ Hip......... LO RO BO
- ❑ Leg......... LO RO BO
- ❑ Foot....... LO RO BO

Other Locations: ________

Actions Affecting Pain

B=Brings on A=Aggravates R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
________	❑	❑	❑
________	❑	❑	❑
________	❑	❑	❑
________	❑	❑	❑

Pain Frequency:

- O Up to 1/4 of awake time
- O 1/4 to 1/2 of awake time
- O 1/2 to 3/4 of awake time
- O Most all the time

Pain Intensity:

- O Doesn't affect daily activities
- O Somewhat affects activities
- O Seriously affects activities
- O Prevents activities

Activities of Daily Living: Using the following 1-5 scale, choose the number that describes the difficulties listed below.

1 = I can do it without any difficulty
2 = I can do it without much difficulty, despite SOME pain
3 = I manage to do it by myself, despite MARKED pain
4 = I manage to do it despite the pain, but only if I have help
5 = I cannot do it at all, because of the pain

Self care Personal Hygiene	1	2	3	4	5
Bathing					
Drying hair					
Brushing teeth					
Putting on shoes					
Preparing meals					
Taking out the trash					
Showering					
Combing hair					
Making the bed					
Tying shoes					
Eating					
Doing laundry					
Washing hair					
Washing face					
Putting on a shirt					
Putting on pants					
Cleaning dishes					
Going to the toilet					

Physical Activities	1	2	3	4	5
Standing					
Walking					
Kneeling					
Bending back					
Twisting left					
Leaning back					
Sitting					
Stooping					
Reaching					
Bending left					
Twisting right					
Leaning left					
Recling					
Squatting					
Bending forward					
Bending right					
Leaning forward					
Leaning right					
Standing for long periods					
Sitting for long periods					
Walking for long periods					
Kneeling for long periods					

Functional Activities	1	2	3	4	5
Carrying small objects					
Lifting weights off the floor					
Pushing things while seated					
Exercising upper body					
Carrying large objects					
Lifting weights off table					
Pushing things while standing					
Exercising lower body					
Carrying brief case					
Climbing stairs					
Pulling things while seated					
Exercising arms					
Carrying large purse					
Climbing inclines					
Pulling things while standing					
Exercising legs					

Social and Recreational	1	2	3	4	5
Bowling					
Jogging					
Swimming					
Ice skating					
Competitive sports					
Dating					
Golfing					
Dancing					
Skiing					
Roller skating					
Hobbies					
Dining out					

Activities of Daily Living: Using the following 1-5 scale, choose the number that describes the difficulties listed below.

1 = I can do it without any difficulty
2 = I can do it without much difficulty, despite SOME pain
3 = I manage to do it by myself, despite MARKED pain
4 = I manage to do it despite the pain, but only if I have help
5 = I cannot do it at all, because of the pain

Difficulties with Traveling	1	2	3	4	5
Driving a motor vehicle					
As a passenger in a motor vehicle					
As a passenger on a train					
Driving for long periods of time					
As passenger in an airplane					

For the 4 sections below, please use the following scale to that best represents your difficulties with Communication, senses, hand functions and sleep.

1 = This area is NOT affected by my condition
2 = This area is SLIGHTLY affected by my condition
3 = My condition MODERATELY restricts my ability in this area
4 = My condition SERIOUSY limits my ability in this area
5 = My condition PREVENTS me from using this ability

Difficulties with Communication	1	2	3	4	5
Concentrating					
Hearing					
Listening					
Speaking					
Reading					
Writing					
Using a keyboard					

Difficulties with Senses	1	2	3	4	5
Seeing					
Hearing					
Touch					
Taste					
Sense of smell					

Difficulties with Hand Functions	1	2	3	4	5
Grasping					
Holding					
Pinching					
Percussive movements					
Sensory discrimination					

Difficulties with Sleep	1	2	3	4	5
Being able to have a normal, restful nights sleep					

Prior Treatment Information:

Prior Similar Symptoms:

Please check the question that best explains your current symptoms:

_____ I have NOT had prior similar symptoms to current complaints

_____ My current complaints DID exist before, but had been dormant for:

Prior symptoms ______ # of months ago
______ # of years ago

_____ My current complaints ALREADY existed and were worsened

Has your HISTORY contributed to your Symptoms?

_____ My history HAS contributed to my current symptoms

_____ My history HAS NOT contributed to my current symptoms

_____ I'm NOT SURE if my history has contributed to my symptoms

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Pregnancy Release (if applicable)
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Signature: ______________________________ Date of last menstrual period: ____________

I authorize **Parent Chiropractic Center** to speak to person(s) listed below regarding any treatments, concerns, financial matters, appointments related to my healthcare.

____
(Relationship to patient)

I have read and fully understand the above statements and accept chiropractic care on this basis.

Signature: ____ Date: ____________________