VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ☐ a.m. ☐ p.m.

Car Insurance Company: _____ Claim # _____ Claim Contact Name/# _____

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

Have you filed a claim yet? No Yes

Do you plan to use an attorney? No Yes

Who was at fault? Me Other Driver

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

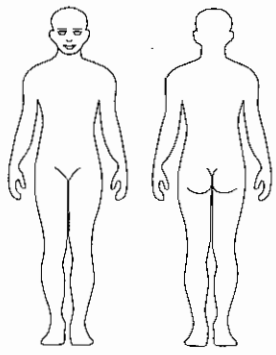
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

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?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Please fill out this page if you do NOT intend on using an attorney

LIVE SMART
Chiropractic & Rehabilitation

Dr. Teresa Crossley, D.C.
Dr. Trevor Crossley, D.C.

Notice of Doctor's Lien

Patient Name:_____ Date of Accident:_____

I do hereby authorize LiveSmart Chiropractic & Rehabilitation to provide examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident I was recently involved.

I hereby authorize to pay directly to said doctor such sums as may be due and owing for medical/ chiropractic service rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums form any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor(s). I hereby further give a Lien of my case to said doctor any and all proceeds of my settlement, judgment or verdict which may be paid to myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical/chiropractic bills submitted by LiveSmart Chiropractic & Rehabilitation for services rendered to me and that this agreement is made solely for said doctors' additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment of verdict by which we may eventually recover said fee. I understand and acknowledge that this office does not accept percentages of said settlement and that the doctor(s) will be paid in full or 100% of any outstanding bill after treatment is completed. I agree to promptly notify said doctor of any change in connection with this accident.

I agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor(s) above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. I further agree that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Please acknowledge this letter by signing below and returning to the doctor's office. I understand and agree that if I do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable immediately.

_____ _____

Patient's Signature Dated

_____ _____

Witness Signature Dated

9625 Black Mountain Rd. Suite 208 • San Diego, Ca 92126 • (858) 634-2225
team@livesmartchiropractic.com

Please fill out this page if you intend on using an attorney

LIVE SMART
Chiropractic & Rehabilitation

Dr. Teresa Crossley, D.C. Dr. Trevor Crossley, D.C.

Notice of Doctor's Lien

Attorney Name:_____ Phone:_____

Patient Name:_____ Date of Accident:_____

I do hereby authorize LiveSmart Chiropractic & Rehabilitation to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing her for medical/chiropractic service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums form any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a Lien of my case to said doctor any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical/chiropractic bills submitted by LiveSmart Chiropractic & Rehabilitation for services rendered to me and that this agreement is made solely for said doctors' additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment of verdict by which we may eventually recover said fee. I understand and acknowledge that this office does not accept percentages of said settlement and that the doctor(s) will be paid in full or 100% of any outstanding bill after treatment is completed. I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

_____ _____

Patient's Signature Dated

Acknowledgement of Attorney

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums form any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor(s) above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The attorney further agrees in that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

_____ _____

Attorney's Signature Dated

9625 Black Mountain Rd. Suite 208 • San Diego, Ca 92126 • (858) 634-2225
team@livesmartchiropractic.com