Well Spine Family Chiropractic, LLC

2995 Baseline Rd. Ste 100 ◦ Boulder, CO 80303 ◦ Office: 720-403-8225 ◦ Fax: 720-458-3937

_____ _____

NAME DATE

COGNITIVE DIFFICULTIES QUESTIONNAIRE

	YES	NO
1. Are you currently experiencing any attention or concentration difficulties?	_____	_____
2. Are you currently experiencing any memory difficulties?	_____	_____
3. Are you able to express yourself as well as you always could?	_____	_____
4. Do you now experience difficulties planning or organizing your daily life?	_____	_____
5. Are you able to solve problems as efficiently as you always could?	_____	_____
6. Do you now become confused (or make a mistake) about where you are?	_____	_____
7. Do you have more difficulty now in calculating or working with numbers?	_____	_____
8. Are you experiencing any vision difficulties?	_____	_____
9. Are you more emotional now than you were previously?	_____	_____
10. Do you believe you are depressed?	_____	_____
11. Are you experiencing frequent headaches?	_____	_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

1. Name _____ Today's date _____
2. Date of accident _____ Time of accident _____ AM/PM
3. Address of accident_____

   City & State of accident _____
4. What direction were you heading? _____Other vehicle was headed? _____
5. Did police come to the accident scene? _____ Were you taken to a hospital? _____

   If so, how were you transported? _____

   Name and address of the hospital? _____

   Were you x-rayed at the hospital? _____
6. Was any other doctor consulted after the accident? ____ Doctor's name? _____

   What was the diagnosis? _____ Any treatment given? _____

   What type of treatment? _____How many treatments? ____
7. Please list any other health care providers consulted for this accident. _____

   _____
8. Where did you feel pain after the accident? _____

   When did you first start to feel this pain? _____
9. Have you ever had complaints in the involved area before? _____

   If so, what were the complaints? _____
10. Since this injury, are your symptoms: Improving? ____ Getting worse? ____ Same____
11. Are your work activities restricted as a result of this accident? _____

    What type of activities are required in your normal work day? _____

    _____

The following questions pertain to you, the patient, and the vehicle you were in.

1. List the year, make, and model of the vehicle you were in: Year _____ Make _____ Model _____
2. Was your car stopped at the time of impact? _____ If no, what is the estimated speed of the car you were in? _____ mph
3. If the car was moving at the time of impact, was it slowing down ___; or was it gaining speed? ___; Were there any skid marks? _____
4. Did your car subsequently hit another car? _____ or another object? _____
5. Was your car pushed ahead or in any other direction as a result of impact? _____
6. Where were you seated in the car? Driver _____ passenger _____ front seat _____ back seat ____
7. Were you wearing a seatbelt? _____ If yes, was it a shoulder-lap belt _____ or lap only _____
8. Were you aware of the approaching collision prior to the impact _____ or did the impact take you by surprise? _____
9. Was the trunk of your body pointed straight forward at the time of impact? _____ If no, which direction was it turned and by how much? _____
10. Was your head pointed straight forward? _____ If no, what direction was it turned and by how much? _____
11. How far is the top of the headrest or seat back from the top of your head? (approximately) _____ inches above _____ below _____
12. Did you lose consciousness (blackout) upon impact? _____ If yes, approximately how long? _____

13. Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

14. What is the damage estimate to the car you were in? _____ Do you have photos? ___

15. Which of the following car parts broke in this accident?

Windshield _____ Front seat back _____
Rt / Lt side window _____ Airbag deployment? Y/N_____
Steering wheel _____ Other _____

16. What bleeding cuts did you get during this accident? _____

What bruises did you get during this accident? _____

17. On what part of the auto did the following body parts hit?

Head hit _____ Rt / Lt hip hit _____
Chest hit _____ Rt / Lt leg hit _____
Rt / Lt shoulder hit _____ Rt /Lt knee hit _____
Rt / Lt arm hit _____ Other _____

****

The following questions pertain to the other vehicle involved in the accident:

1. What is the year, make, and model of the other vehicle? Year _____

   Make _____Model _____ Describe damage to the other

   vehicle_____ Any other cars involved? _____

2. Was the other car moving at the time of impact? _____ If yes, what was the

   approximate speed? _____ mph

3. If the other car was moving at the time of the collision, was it slowing down? _____

   gaining speed? _____ Any skid marks? _____

1. Who is your insurance company? (please include address and phone #) _____

   _____

2. Did you file a claim? _____ Claim #: _____

3. Adjustor's name _____ Telephone # _____

4. Driver of car in which you were in? (if applicable) _____Insurance company? _____ policy # _____

5. Does the driver have a Medical Pay (Med Pay) policy? ___ Amount of policy? _____
   Approximate amount left on Med Pay? _____

6. What are the UM/UIM policy limits? _____

7. Driver of the other car? (if applicable) _____

Insurance company? _____ policy # _____

Claims adjustor _____ Telephone #: _____

8. Who received the citation for the accident? _____ For what? _____

9. Have you retained an attorney? _____ If yes, attorney's name and address _____

   _____

10. Do you have health insurance? _____ Company? _____

****

If you have been in previous auto accidents, please list the year each was in:

1. _____ Injuries sustained?_____Claims made?____ Treatment?_____
2. _____ Injuries sustained?_____Claims made?____ Treatment?_____

_____ _____

Name printed Signature

_____

Date

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PATIENT / CLAIMANT _____

PATIENT INSURANCE CARRIER _____

CITED DRIVER INSURANCE CARRIER _____

DATE OF ACCIDENT _____

☐ I have a **med-pay policy** on my automobile insurance policy, and I understand that my auto insurance company will be billed directly for services rendered in this office.
After the med-pay limits are reached, I understand that I will be responsible for payment of all charges at the time of service until I am discharged from care from this office.

☐ I do not have a med-pay policy or health insurance coverage for injuries related to this accident. I understand that **I am responsible for 100% of charges** incurred at the time services are rendered.

☐ I have retained an attorney, and there is a signed and **executable lien** on file in this office. I agree to pay a co-payment of 50% at the time of service. Well Spine Family Chiropractic, LLC will defer collection of any remaining balance due until settlement of my case.

In the event the automobile insurance carrier fails to pay for services for this injury or condition, or it is determined the injury or condition is not a result of this accident; I understand that I am responsible for any remaining balance due.

_____ _____
Name printed Date

_____
Signature

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CLAIMANT _____

INSURANCE CARRIER _____

In the event that the insurance carrier fails to compensate for this injury or condition, I, _____, hereby agree to pay Well Spine Family Chiropractic the usual and customary fees for services rendered.

_____ _____

Name Printed Signature

_____

Date

Well Spine Family Chiropractic, LLC

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I authorize payment of medical benefits to the undersigned physician or supplier for all services rendered in the offices of Well Spine Family Chiropractic, LLC.

_____ _____

Patient Name (printed) **Date**

_____

Patient Signature

- **Dr. Amber Thompson, DC, CACCP**
- **Dr. Michelle Withington, DC**