AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____

Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Who referred you to our office? _____

Social Sec.# _____ Business Phone _____ Company Name _____

Company Address _____

Please explain in detail how your accident happened? _____

_____

_____

Driver of other vehicle (if any) _____

Name of person who has made contact with you _____

Insurance Company _____

Policy No. _____

Claim No. _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____

Policy No. _____

Claim No. _____

Name of person who has made contact with you _____

Have you retained an attorney? ☐ Yes ☐ No ☐ Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ ☐ AM ☐ PM ____/____/_____

You were heading? ☐ North ☐ South ☐ East ☐ West on _____ (street or highway)

Other vehicle was heading? ☐ North ☐ South ☐ East ☐ West on _____ (street or highway)

Number of people in vehicle _____

Were police notified? ☐ Yes ☐ No Did head strike windshield or object? ☐ Yes ☐ No

Were you knocked unconscious ☐ Yes ☐ No If so, for how long _____

You were struck from? ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were? ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that day ☐ Next day ☐ When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any doctor consulted after the accident? ☐ Yes ☐ No

If so, give doctor's name _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

Doctor's 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 before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since the injury, are your symptoms ☐ Improving? ☐ Getting worse? ☐ The same?

Motor Vehicle Accident Survey

(Please Circle a response for each question)

1. What was your position in the vehicle?
   a. driver
   b. rear right passenger
   c. front passenger
   d. rear left passenger

2. What type of vehicle were you driving?
   a. compact car
   b. mid sized car
   c. full sized car
   d. SUV
   e. truck
   f. mini van

3. What speed were you traveling at the time of the accident?
   a. stopped at a light.
   b. slowed down at an intersection
   c. at a complete stop
   d. moving slowly
   e. traveling at appoximately___MPH

4. Who hit who?
   a. was struck by another vehicle
   b. struck another vehicle
   c. struck a stationary object

5. What was your vehicles point of impact?
   a. on the front middle
   b. on the front right
   c. on the front left
   d. on the middle rear
   e. on the right rear
   f. on the left rear
   g. on the right side front quarter panel
   h. on the left side front quarter panel
   i on the right side rear quarter panel
   j. on the left side rear quarter panel
   k. on the middle right side
   l. on the middle left side

6. What speed was the other vehicle traveling?
   a. stopped at a light
   b. slowing down at an intersection
   c. moving slowly
   d. merging into traffic
   f. traveling at ___MPH

7. What was the other vehicles point of impact?
   a. front middle
   b. front right
   c. front left
   d. middle rear
   e. right rear
   f. left rear
   g. right front quarter panel
   h. left front quarter panel
   i. right rear quarter panel
   j. left rear quarter panel
   k. right middle
   l. left middle

8. Were you wearing seat restraints? Yes/No
   a. full lap and shoulder restraint
   b. lap restraint

9 . What position was you vehicle head rest in?

a. lowest position
b. highest position
c. middle position
d. vehicle not equipped with a head rest

10. Did your vehicle's air bag deploy? Yes/No

11. Were you prepared for the impact?

a. I was completely surprised the accident.
b. I saw the collision coming.
c. I saw the collision coming and braced appropriately.

12. What position was your body in just prior to the impact?

a. a straight position
b. a tilted forward position
c. a.position rotated to the left.
d. a position rotated to the right.
e. a position that cannot be remembered

13. What happened to your body at the moment of impact?

a. my body was tensed for the impact.
b. my body was whipped violently forward and backward.
c. my body was violently torgued and twisted
d. my body was thrown over the seat.
e. my body was thrown from the vehicle.
f. my body was pinned in the vehicle.
g. my body was badly cut and bruised.

14. What was your emotional state immediately following the accident?

a. I was not rendered unconscious by the impact of the accident.
b. I was not rendered unconscious but I was shaken and disoriented.
c. I was rendered unconscious by the impact of the accident.

15. Did you receive medical attention at the scene of the accident? Yes/No

16. Where did you go immediately following the accident?

a. I was taken to the hospital.
b. I was taken home.
c. I was taken to a personal physician.
d. I was taken to this office.
f. I resumed my normal activities.

17. List each of your body parts that struck the following vehicle parts during the accident:

a. Dashboard
b. Windshield
c. Steering Wheel
d. Right Door
R/L Side of head
R/L Shoulder
R/L Arm
R/L Elbow
e. Left Door
f. Seat Frame
g. Other
R/L Wrist
R/L Knee
R/L Ankle

AUTHORIZATION OF DOCTOR/INSURANCE ADJUSTER LIEN

INSURANCE ADJUSTER INFORMATION / MEDICAL PROVIDER INFORMATION

NAME:_____ NAME:
ADDRESS:_____ ADDRESS:
CITY:_____ CITY:
STATE/ZIP:_____ STATE/ZIP:
PHONE:_____ PHONE:

Sitzmann Chiropractic
224 Feaster Road Suite C
Greenville, SC 29615
864-458-8888

PATIENT INFORMATION:

NAME:_____ BIRTHDAY_____ SEX_____
ADDRESS:_____ SOC.SEC.#_____
CITY:_____ STATE:_____ CLAIM#_____
TELEPHONE: (H)_____ (W)_____
MARITAL STATUS: ( )SINGLE ( ) MARRIED ( ) OTHER
EMPLOYMENT STATUS: ( )EMPLOYED STUDENT: ( ) FULL ( ) PART TIME

WAS INJURY RELATED TO?
EMPLOYMENT: ( ) YES ( ) NO
AUTO ACCIDENT: ( ) YES DATE:_____ STATE:_____ ( ) NO
OTHER ACCIDENT: ( ) YES ( ) NO

I do hereby authorize the above-named medical provider to furnish you, the insurance Adjuster with a full report of the findings and prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, the insurance Adjuster, to pay directly to said medical provider such sums as may be due and owing them for medical service rendered me both by reason of this accident and by reason of any other bills that are due him and to withholding such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said provider. And I further give a Lien on my case to said provider against sufficient proceeds of my settlement, judgment or verdict which may be paid to you, my Insurance Adjuster, or myself, as a result of the injuries in connection therewith.

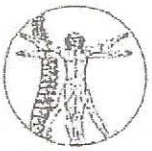
I hereby instruct that in the event another Insurance Adjuster is substituted in this matter, the new Insurance Adjuster honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by the substituted Insurance Adjuster.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by them for service rendered me and that this agreement is made solely for said provider's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

_____ _____
PATIENT/GUARDIAN SIGNATURE PATIENT/GUARDIAN NAME PRINTED DATE

The undersigned being Insurance Adjuster of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said provider above named and to issue such sums withheld to the above named provider.

_____ _____
INSURANCE ADJUSTER SIGNATURE INSURANCE ADJ. NAME PRINTED DATE



Sitzmann Chiropractic, L.L.C.

224 Feaster Rd. Suite C
Greenville, S.C. 29615
(864) 458-8888

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR, PRIVATE AND GROUP ACCIDENT, AND HEALTH INSURANCE.

Patient: _____

Employer: _____

Claim/Group#: _____

SSN/ID#: _____

I herby instruct and direct _____Insurance Company to pay by check made out and mailed to:

Sitzmann Chiropractic, L.L.C.
224 Feaster Rd. Suite C
Greenville, SC 29615

If my current policy prohibits direct payment to doctor, then I herby also instruct and direct you to make out the check to me and mail it as follows:

Sitzmann Chiropractic, L.L.C.
224 Feaster Rd. Suite C
Greenville, SC 29615

The professional or medical expense benefits allowable and otherwise payable to me, under current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment of Benefits shall be considered as effective and valid as the original.

_____ _____
Signature of Policyholder Date

_____ _____
Signature of Claimant Date

Dr. Frank A. Sitzmann

Sitzmann Chiropractic 224 Feaster Rd. Suite C
Greenville, SC 29615

Re: Medical Reports and Doctor's lien

I do hereby authorize Frank A. Sitzmann D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Sitzmann Chiropractic such sums as may be due and owed them for medical services 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 for any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against 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 bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of him awaiting payment and I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to Sitzmann Chiropractic. 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 will require me to make payments on a current basis.

_____ _____

Patient date Witness date

The undersigned, being attorney of record for the above named patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

_____

Attorney date

Please sign and return one copy to our office