



ARCHER FAMILY WELLNESS CLINIC

Dr. Donna M. Archer
Chiropractic Physician

Personal Injury Billing Information

Name _____ Date _____

Driver's Auto Insur. Co. _____

Policy # _____ Phone # _____

Claims Ins. Co. Address _____

Claims Adjuster Claim # _____

Attorney's Name _____

Attorney's Address _____

Other Driver's Name _____

Ins. Co. Phone _____

Policy # _____ Claim # _____

Date of Injury ___/___/_____

All of the above information is correct to the best of my knowledge. I agree that **ARCHER FAMILY WELLNESS CLINIC / Dr. Donna M. Archer**, will bill my insurance company, however, I also agree that any balance owing is ultimately my responsibility. I further agree to pay any outstanding balance owed at the time of settlement with the party-at-fault or their insurance company.

Signature _____

Date _____



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ARCHER FAMILY WELLNESS CLINIC
Donna Maria Archer, DC

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Patient Name: _____ Date: _____
Home Phone: _____ Cell: _____ Work: _____
Address: _____ City, State, Zip: _____
E-mail: _____ Date of Birth: _____
Driver's Lic. #: _____ ST: _____ Social Security #: _____
Date of Accident: _____ Place: _____
Your Attorney: _____ Phone: _____
Was this an on-the-job injury? Y N Explain: _____

Employer: _____ Phone: _____
Address: _____

INFORMATION FOR VEHICLE YOU WERE RIDING IN:

Driver: _____ Phone: _____
Owner: _____ Phone: _____
Address: _____
Insurance Co: _____ Claim #: _____
Adjuster Name: _____ Phone: _____
Address: _____
Uninsured / Underinsured Motorist Insurance (UM / UIM)? Yes No
Personal Injury Protection? Yes No

INFORMATION FOR OTHER VEHICLE:

Driver: _____ Phone: _____
Owner: _____ Phone: _____
Address: _____
Insurance Co: _____ Claim #: _____
Adjuster Name: _____ Phone: _____
Address: _____

Who has been determined to be at fault? _____

ARCHER FAMILY WELLNESS CLINIC
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MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____

Date: _____

INFORMATION ON OTHER VEHICLE:

- 1 Year: _____ Make: _____ Model: _____
2 Body type: 2 door 4 door Convertible SUV
 Pickup Van Other: _____
3 Was vehicle carrying any extra weight? Yes No
Explain: _____
4 Do you know damage estimate? _____

ACCIDENT INFORMATION:

- 1 Were you wearing a seat belt? Yes No
 Lap and shoulder Lap only Shoulder only None
2 If you were using the shoulder belt, how was it positioned?
 Neck Upper chest Other: _____
3 Did you adjust the headrest? Yes No Not adjustable No Headrest
4 The headrest was where in relation to the center of your head?
 Above Below Center Not Sure
5 How far behind your head was the headrest?
 In Contact Under 1 inch Over 1 inch Not Sure
6 Do you recall your head striking the headrest? Yes No
7 How was your seat positioned at time of impact?
 Tilted back Tilted forward Upright
8 Did your seat change position upon impact? Yes No Not sure
 If yes, was it: Tilted back Tilted forward Upright
9 Did your seat back: Break Bend Release failed to hold Not sure
10 Airbags: None Did not deploy Deployed
11 Were you hit by the airbag? Yes No Not sure
 If yes, where were you hit? Face Arms Body Legs
12 Did the airbag cause injury to you? Yes No Not sure
 If yes, where were you injured? Face Arms Body Legs
Other: _____

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MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____

Date: _____

COLLISION DYNAMICS

1 From what direction was your vehicle struck? Front Back Right Left

2 Was impact direct or at an angle? Direct Angled Describe: _____

3 Did your vehicle move after impact? Yes No Not sure
Describe: _____

4 How far apart were vehicles after impact? In contact Several feet Over 10 feet

5 Did driver brake after impact? Yes No Not sure

6 Was vehicle moving at impact? Yes No Estimate of speed: _____

7 Was there visible damage to the vehicle you were riding in? Yes No
Describe: _____

8 What did you hear or see immediately before and during the collision?

9 Did any witnesses identify themselves? Yes No
Names: _____

BODY POSITION AND IMPACT

1 How was your head positioned at time of impact?
Straight ahead Turned left Turned Right Tilted up Tilted down Not sure

2 How were you sitting at time of impact?
Upright Leaning Forward Leaning Back Leaning Right Leaning Left Not sure

3 Were you holding the steering wheel at impact? Yes No Not sure Not driver

4 If you were driving, where were your hands? Left: _____ Right: _____

5 Were you aware that the collision was about to occur? Yes No

6 Did you have time to brace? Yes No Describe: _____

7 Were you wearing glasses or a hat? Yes No
If yes, where were they after accident? _____

8 Did any objects within the vehicle (including trunk) move? Yes No
Describe: _____

9 Did your body strike anything inside the vehicle? Yes No
Describe: _____

10 Any cuts, scrapes or bruises from impact within vehicle? Yes No
Describe: _____

11 Any windows break? Yes No If yes, were you cut as a result? Yes No

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MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____

Date: _____

INJURIES AND MEDICAL TREATMENT

1 When did you first become aware that you were injured?
Immediately Within ___ minutes Within ___ hours ___ Days ___ Weeks

2 What was the first injury you noticed? _____

3 Did you lose consciousness? Yes No Not sure How long? _____

4 Circle any areas where you suffered cuts, bruises, scrapes or swelling: Head
Neck Shoulder R / L Arm R / L Back Chest Leg R / L Knee R / L Ankle R/L

5 Were you treated at scene? Yes No Paramedics Ambulance crew Other

6 Were you transported to hospital or clinic? Yes No
How? _____ Where? _____

7 For what conditions were you treated? _____

8 Were X-rays, MRI or CT scans performed? Yes No

9 Have you been examined by and/or treated by any other doctors, chiropractors, physical therapists, massage therapists, etc., since the collision? Yes No
List: _____

10 For what conditions were you treated? _____

11 Were x-rays, MRI or CT scans performed? Yes No

12 If you did not seek medical treatment within one week explain why? _____

13 Have you had any pain tingling or numbness anywhere since the accident? Yes No
Describe: _____

14 Have you had any dizziness, vision or balance problems since the accident? Yes No
Describe: _____

15 Have you had any jaw pain since accident? Yes No

16 Have you had any jaw popping or trouble eating/chewing since the accident? Yes No

17 Have you had headaches? Yes No If yes, describe frequency, severity & sensation:

18 Have you had neck pain? Yes No Describe: _____

19 Have you had back pain? Yes No Describe: _____

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Name: _____

Date: _____

20 Have you unable to work since accident? Yes No How long? _____

21 Did you have a doctor's release from work? Yes No Doctor: _____

22 Your occupation: _____

23 Have you noticed any pain or difficulty performing any of the following activities since the accident?

- | | | | |
|--|------------|--------------------------------------|-----------------------|
| Reaching forward | Sitting | Stooping | Lifting up to 10 lbs. |
| Reaching down | Bending | Kneeling | Lifting 10 - 20 lbs. |
| Reaching up | Pushing | Crouching | Lifting 20 - 50 lbs. |
| Handling small items | Pulling | Crawling | Lifting repetitively |
| Pouring coffee/milk | Walking | Climbing | Tasting/Smelling |
| Keyboarding | Stuttering | Yawning | Comprehension |
| Word choices | Talking | Hearing | Seeing close up |
| Depth perception | Chewing | Vision | Seeing far away |
| Difficulty following conversation | | Confusion or stress with loud noises | |
| Confusion or stress in "Busy" places (mall, restaurants, etc.) | | | |

24 What leisure, social or domestic activities have you had to avoid?

PAST MEDICAL HISTORY

1 Have you suffered an injury to your head, neck or back in the past? Yes No

Explain area and how injured: _____

2 Have you made a personal injury or workers compensation claim in the past? Yes No

Explain: _____

3 Have you been treated by a health care professional for head, neck or back pain? Yes No

Explain: _____

4 Have you received physical therapy for any condition? Yes No

Explain: _____

5 Did you have any physical complaints before this accident? Yes No

Explain: _____

