Lighthouse Chiropractic

**IF YOU WERE THE DRIVER OF YOUR OWN VEHICLE, SOMEONE ELSE'S VEHICLE OR A PASSENGER IN THE VEHICLE, ANSWER THIS SECTION COMPLETELY.**

Your Auto Insurance Company
Name_____
Address_____
Policy #_____
Purchased from_____
Phone #_____

Vehicle owner's name
_____
Address_____
City_____State____Zip_____

Your driver's name_____
Address_____
City_____State____Zip_____

Your Health Insurance Company
Name_____
Address_____
Policy #_____
Purchased from_____
Phone #_____

Vehicle Owner's Auto Insurance Company
_____
Address_____
City_____State____Zip_____
Policy #_____
Purchased from_____
Phone #_____

Your driver's Auto Insurance Company
_____
Name_____
Address_____
Policy #_____
Phone #_____

**IF ANOTHER VEHICLE WAS INVOLVED IN THE COLLISION, ANSWER THIS SECTION COMPLETELY.**

Driver of other vehicle:
Name_____
Address_____
City_____State____Zip_____

Other driver's Auto Insurance Company:
Name_____
Address_____
City_____State____Zip_____
Policy #_____
Purchased from_____
Phone #_____

**IF THE DRIVER WAS OPERATING SOMEONE ELSE'S VEHICLE:**

Vehicle owner's name:
Name_____
Address_____
City_____State____Zip_____

Vehicle owner's Auto Insurance Company:
Name_____
Address_____
City_____State____Zip_____
Policy #_____
Purchased from_____
Phone #_____

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571*248*6488

**THE FOLLOWING INFORMATION IS REQUIRED OF ALL PATIENTS**

Has this accident been reported to the police? _____Yes _____No

If yes, did they come to the scene of the accident? _____Yes _____No

If yes, did they cite anyone with a traffic violation? _____Yes _____No

If yes, Whom? _____myself _____my driver _____the other driver

Have you reported this accident to any insurance company? _____Yes _____No

If yes, Which one(s) _____my own _____my drivers _____the owner of my driver's vehicle
_____the other drivers _____the owner of the other driver's vehicle

If a claim number has been assigned, please state _____
Claim #

Have you retained the services of an attorney? _____yes _____no.

If yes, Attorney's name _____
Address_____
City _____ State _____Zip_____
Phone # _____Fax #_____

The information given in this questionnaire is true and accurate to the best of my knowledge.

Signed _____ Date_____

The staff of this chiropractic center appreciates your taking the time to gather this vital information. Please be assured we will do everything possible to assist you in your recovery. We will also make every effort to secure any coverages that will enable you to receive whatever care you may need.

Thank you for your cooperation.

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**ACCIDENT HISTORY QUESTIONNAIRE**

1. Date of accident:_____
2. Time:_____AM/PM
3. Driver of car:_____
4. Where were you seated:_____
5. Who owns the car:_____
6. Year & Model of your car:_____
7. Year & Model of the other car:_____
8. What was the approximate damage done to your car? $_____
9. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other (describe)
   _____
10. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other (describe)
    _____
11. Where was your car struck:

FRONT REAR LEFT SIDE RIGHT SIDE

12. Type of accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front impact ☐ Rear-end ☐ Non-collision

13. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:
_____
14. Did you see the accident coming? ☐ Yes ☐ No
15. Did you brace for the impact? ☐ Yes ☐ No
16. Were seatbelts worn? ☐ Yes ☐ No
17. Were shoulder harnesses worn? ☐ Yes ☐ No
18. Does your car have headrests? ☐ Yes ☐ No
19. If yes, what was the position of the headrests compared to your head before the accident?

    ☐ Top of headrest even with bottom of head
    ☐ Top of headrest even with top of head
    ☐ Top of headrest even with middle of neck
20. Was your car braking? ☐ Yes ☐ No
21. Was your car moving at the time of the accident? ☐ Yes ☐ No
22. If yes, how fast would you estimate your speed?_____mph
23. How fast would you estimate the other car was going?_____mph
24. Head/body position at the time of impact:
    ☐ Head turned left / right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right / left
    ☐ Head straight forward ☐ Other:_____
25. As result of the accident were you ☐ Rendered unconscious ☐ In shock
    ☐ Dazed / Confused
    ☐ Other:_____

26. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
27. Were you wearing a hat or glasses? ☐ Yes ☐ No
28. Could you move all parts of your body? ☐ Yes ☐ No
29. If no, what parts couldn't you move and why?_____
_____
30. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
31. If no, why not?_____
32. Did you receive any bleeding cuts? ☐ Yes ☐ No If yes, where?_____
33.Did you get any bruises? ☐ Yes ☐ No If yes, where?_____
34. Please describe how you felt_____
Immediately after the accident:_____
Later that day:_____
The next day:_____
35. Check symptoms apparent since the accident:

| | | |
|---|---|---|
| ☐ Headache | ☐ Neck pain | ☐ Mid back pain |
| ☐ Eyes light sensitive | ☐ Pain behind eyes | ☐ Dizziness |
| ☐ Fainting | ☐ Sleeping problems | ☐ Numbness in fingers |
| ☐ Numbness in toes | ☐ Loss of smell | ☐ Loss of taste |
| ☐ Loss of Memory | ☐ Fatigue | ☐ Shortness of breath |
| ☐ Irritability | ☐ Depression | ☐ Ringing/Buzzing |
| ☐ Loss of balance | ☐ Tension | ☐ Cold hands |
| ☐ Cold feet | ☐ Diarrhea | ☐ Constipation |
| ☐ Chest pain | ☐ Nervousness | ☐ Cold sweats |
| ☐ Anxious | ☐ Low back pain | ☐ Other:_____ |

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36. Occupation:_____
37. Employer:_____
38. Have you missed time from work? ☐ Yes ☐ No
39. If yes, full time off work:_____to _____
40. If yes, part time off work:_____to _____
41. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
42. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Drove own car ☐ Someone else drove me
☐ Other _____
43. Doctor #1 name_____
44. First visit date:_____
45. Were you examined? ☐ Yes ☐ No
46. Were X-rays taken? ☐ Yes ☐ No
47. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars

48. If yes, what kind of treatment did you receive?_____

49. What benefits did you receive from the treatment?_____

50. Date of last treatment?_____

51. Doctor #2 name?_____

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52. First visit date:_____
53. Were you examined? ☐ Yes ☐ No
54. Were X-rays taken? ☐ Yes ☐ No
55. Did you receive treatment? ☐ Yes ☐ No
56. If yes, what kind of treatment did you receive?_____
57. What benefits did you receive from the treatment?_____
58. Date of last treatment?_____
59. Do you have an attorney on this claim? ☐ Yes ☐ No
60. If yes, who?_____
Address:_____
City:_____State:_____Zip:_____Phone:_____

Illustrate below how the accident happened.

Past medical history: Place an (X) if it applies and describe.
☐ None related to current complaints ☐ Hospital or operation ☐ Auto accident
☐ Work accident ☐ Illness ☐ Other Describe:_____

## SYSTEM REVIEW Place an (X) next to the symptoms you know you have.

### Genito-Urinary System

☐ Bladder trouble ☐ Excessive urination ☐ Scanty urination
☐ Painful urination ☐ Discolored urine

### Gastro-Intestinal System

☐ Poor appetite ☐ Excessive hunger ☐ Difficulty chewing
☐ Difficulty swallowing ☐ Excessive thirst ☐ Nausea
☐ Vomiting food ☐ Abdominal pain ☐ Diarrhea
☐ Constipation ☐ Black stool ☐ Bloody stool
☐ Hemorrhoids ☐ Liver trouble ☐ Gall bladder trouble
☐ Weight trouble

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## Nervous System

- ☐ Numbness
- ☐ Dizziness
- ☐ Muscle Jerking
- ☐ Confusion
- ☐ Loss of Feeling
- ☐ Fainting
- ☐ Convulsions
- ☐ Depression
- ☐ Paralysis
- ☐ Headaches
- ☐ Forgetfulness

## Cardio-Vascular System

- ☐ Chest pain
- ☐ Persistent cough
- ☐ Rapid heartbeat
- ☐ Lung problems
- ☐ Pain over heart
- ☐ Coughing phlegm
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Difficulty breathing
- ☐ Coughing blood
- ☐ Heart problems
- ☐ Other

## Eye, Ear, Nose and Throat System

- ☐ Eye strain
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Sore mouth
- ☐ Speech difficulty
- ☐ Eye inflammation
- ☐ Ear noises
- ☐ Nose pain
- ☐ Sore throat
- ☐ Dental problems
- ☐ Vision problems
- ☐ Ear discharge
- ☐ Nose bleeding
- ☐ Sore gums

## Musculo-skeletal Systems

- ☐ Low back problems
- ☐ Pain between shoulders
- ☐ Neck problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Ruptures
- ☐ Broken Bones

**Lighthouse Chiropractic Clinic**
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# LIABILITY-AUTHORIZATION & ASSIGNMENT OF BENEFITS

TO: Name: _____

Street Address:_____

City/State/Zip: _____

RE: Name: _____

Street Address: _____

City/State/Zip: _____

I, the above referenced client, do hereby authorize Dr. Michael Gaitonde (chiropractor) to furnish _____ (payer) any and all bills, records, and information regarding my medical history, physical condition, examination, diagnosis, treatment, prognosis, and the like relating to my care (or my child's care, if a minor) at Lighthouse Chiropractic.

I hereby assign and authorize any and all available benefits to be paid directly to Dr. Michael Gaitonde by the above said payer. If my policy prohibits direct assignment of benefits to the provider, please forward checks made payable to me to the provider's address listed above.

I hereby acknowledge that I have been made aware of the standard fees and charges established by the above named chiropractor for the treatment that I will be receiving, and I agree that said fees and charges are reasonable. I hereby agree that I will not take any action that would compromise or reduce, or attempt to compromise or reduce the fees and charges that are incurred during care with the above named chiropractor.

I understand that this assignment in no way relieves me of my personal and primary obligation to pay for services/supplies received, but rather serves as a lien against any payable benefits and/or any bodily injury settlement(s).

_____ _____
(Client Signature (signature constitutes acceptance) Date

_____ _____
Witness Signature / Title Date