Motor Vehicle Accident

Name: ____ Today's Date: _______________________

Date & Time of Accident: _________ ❑ a.m. ❑ p.m. Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued? ____

Number of people in accident vehicle? _____

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

Was a police report filed?. . . . . ❑ Yes ❑ No

Were there any witnesses? . . . . ❑ Yes ❑ No

Were you wearing your seat belt? . . . . . ❑ Yes ❑ No

Was this vehicle equipped with airbags? ❑ Yes ❑ No If yes, did it/they inflate? ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest? ❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another vehicle ❑ Other Other, explain:____________________________

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe:____

Make & model of the vehicle you were occupying: ____

Name of location/street on which you were traveling:____

In which direction were you headed? ❑N ❑S ❑E ❑W /hat was the approx. speed of your vehicle?_____

Did the impact to your vehicle come from the: ❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact were you facing: ❑Right ❑Left ❑Forward 'ere you: ❑ aware or ❑ surprised by the impact

If accident vehicle made impact with another vehicle(s):

Make/Model of other vehicle(s):____

Direction other vehicle was headed? ❑N ❑S ❑E ❑W ›eed of the other vehicle: ____________________

In your words please describe the accident: ____

____

____

Did accident render you unconscious? ❑ Yes ❑ No f yes, for how long?____________________________

Please describe how you felt immediately after the accident:_______________________________________

____

Caroline Peterson, DC, PhD, MPH – Chiropractic Physician, Retired Midwife, Researcher
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Have you gone to a hospital or seen any other doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of hospital and/or attending doctor: ____________________ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: ____________________

Were X-rays taken? ❑ Yes ❑ NoWas medication prescribed? ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Is your condition getting worse?

Indicate your degree of comfort while performing the following activities:

Have you retained an attorney? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident: ____________________

____

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other ____________________

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? ____________

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

❏ Standing ❏ Driving ❏ Operating equipment
❏ Sitting ❏ Twisting ❏ Work with arms above head
❏ Walking ❏ Crawling ❏ Typing
❏ Lifting ❏ Bending ❏ Stooping

❏ Other ____

What positions can you work in with minimum physical effort and for how long? _________________________

____

Prior to the injury were you capable of working on an equal basis with others your age?

Do you work with others who can help you with any heavy lifting?

While in recovery, is there any light duty work you could request?

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❏ Yes ❏ No ❏ N/A

❏ Yes ❏ No ❏ N/A

IRREVOCABLE ASSIGNMENT AND CONSENT TO DISBURSEMENT

Patient Name: DOB:

I do hereby irrevocably assign to Caroline Peterson at Bright Life, 1221 SE Madison St, Portland, Oregon 97214, that portion of any settlement, claim, judgment, award or verdict arising out of the motor vehicle accident that occurred on ________________ (Date) necessary to satisfy in full outstanding medical bills at the time of said settlement, claim, judgment, award or verdict.

I hereby irrevocably direct the insurance carrier and/or attorney to make payment directly to Caroline Peterson at Fertile Ground Family Center sums necessary to fully and completely satisfy the outstanding balance due to her by reason of her periodic billing, without contest as to the reasonableness of the billing. In the event I later dispute the reasonableness of charges, my dispute shall have no effect on my irrevocable instructions for payment of this bill, provided however, that I reserve the right to contest the reasonableness of charges subsequent to payment as provided herein.

I understand that regardless of the recovery obtained in the claim I have made for injury to me, I am directly and fully responsible to Caroline Peterson at Fertile Ground Family Center for all billings issued by and for services rendered to me unless my case is accepted under workers compensation law in the state of Oregon.

This agreement is made solely for Fertile Ground Family Center's agreement to extend credit to me for services performed. My obligation to Fertile Ground Family Center is not contingent upon any settlement, claim, judgment, and/or verdict by which I may eventually recover a fee. This assignment and consent to disbursement cannot be revoked, cancelled or terminated.

Patient/Guardian Signature

Date

Name of other party involved in accident

Insurance Company of Patient

Insurance Company of other party

Policy & Claim Number

Policy & Claim Number

Adjuster's Name and Phone Number

Adjuster's Name and Phone Number

Patient's Social Security Number

Attorney representing other party

Pediatric Accident Form

Patient Name: ________________________________ DOI ________: DOB: _________

Parent's Name(s): ___________________________________

Claim#: ________________________ Today's Date: ________________

1. Was your child injured in an automobile accident? YES NO
2. Was your child riding in a "car seat"? YES NO
3. Was the car seat in the REAR SEAT or FRONT SEAT, facing FORWARD or BACKWARD?
4. Was your child in a "booster" seat? YES NO
5. Was the vehicle struck from the : REAR / FRONT / LEFT SIDE / RIGHT SIDE
6. List any visible bumps, bruises, scrapes, cuts, etc. on your child that were caused by this accident:
7. Has there been a change in your child's eating habits? YES NO
8. Has there been a change in your child's sleeping habits? YES NO
9. Has there been a change in your child's disposition? YES NO
10. Does your child cry if a parent attempts to change its sleeping position? YES NO
11. Does your child wake up crying frequently at night? YES NO
12. Does your child have a fever of unknown origin? YES NO

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13. Does your child have a loss of appetite or other eating disorders? YES NO

14. Has your child recently become IRRITABLE / RESTLESS / GRUMPY? YES NO

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