CHIROPRACTIC DEL SOL

1619 E. McDowell Rd. Suite B Phoenix, AZ 85006

AUTOMOBILE ACCIDENT HISTORY FORM

NAME: _____ DATE: _____/_____/_____

Date of Accident: _____/_____/_____ Time of accident: _____:_____ AM/PM

City of Accident:_____ Street of Accident: _____

Road conditions at the time of the accident: ☐ WET ☐ DRY ☐ ICY ☐ OTHER:_____

Is there a Police Report? ☐ YES ☐ NO

Were you the: ☐ Driver ☐ Passenger

Did you go to the hospital? ☐ YES ☐ NO

If yes, what is the name of the hospital? _____

How did you get to the hospital? _____

What parts of your body were X-Rayed at the hospital? _____

What did the hospital do you for your injuries? _____

How long did you stay at the hospital? _____

Did you sustain any bleeding cuts or bruises during this accident ☐ YES ☐ NO

If yes, where?_____

Were you aware of the approaching collision prior to the impact, or did the impact catch you by surprise? (PLEASE CIRCLE)

AWARE SURPRISED

Did you lose consciousness (black out) upon impact? ☐ YES ☐ NO

If yes, length of time? _____

Did you experience a flash of light or explosion in your head? ☐ YES ☐ NO

Did you experience: (PLEASE CIRCLE)

DIZZINESS CONFUSION DISORIENTED LIGHT HEADED

NAUSEATED BLURRED VISION RINGING/BUZZING IN EAR

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following? (PLEASE CIRCLE)

RESTLESSNESS IRRITABLE CONCENTRATING

SLEEPLESSNESS FORGETFULNESS MEMORY LOSS

Reduced tolerance to heat or alcohol ☐ YES ☐ NO or Other: _____

Were you wearing a seatbelt? ☐ YES ☐ NO

If yes, Which kind? (PLEASE CIRCLE)

Lap seatbelt Shoulder-Lap seatbelt

Did you receive any injury or bruise from the seatbelt? ☐ YES ☐ NO

If yes, please describe:_____

How far is the top of the headrest or seatback from the top of your head?
_____Inches _____Above _____Below

Was your head pointed straight in the forward position? □ YES □ NO

If no, which direction was it pointed? _____

On what part of the vehicle, did your following body parts hit?

_____ HEAD _____ CHEST
_____ SHOULDER (RIGHT) _____ SHOULDER (LEFT)
_____ ARM (RIGHT) _____ ARM (LEFT)
_____ HIP (RIGHT) _____ HIP (LEFT)
_____ LEG (RIGHT) _____LEG (LEFT)
_____ KNEE (RIGHT) _____KNEE (LEFT) _____ OTHER

List the YEAR, MAKE and MODEL, of the vehicle you were in:

_____ YEAR _____ MAKE _____MODEL

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following car parts broke during the accident? (PLEASE CIRCLE)

____WINDSHIELD ____FRONT SEAT ____WINDOW (RIGHT) (LEFT)

____STEERING WHEEL ____OTHER ____ OTHER

Was your car stopped at the time of the impact? □ YES □ NO

If yes, was the driver's foot also on the brake? □ YES □ NO

If no, please estimate the speed of the vehicle you were in? _____ MPH

If your vehicle was moving at the time of the impact, was it: (PLEASE CIRCLE)

SLOWING DOWN GAINING SPEED TRAVELING AT THE STEADY RATE OF SPEED

List the YEAR, MAKE and MODEL, of the other vehicle:

_____ YEAR _____ MAKE _____MODEL

Was the other car moving at the time of the impact, □ YES □ NO

If yes, please estimate the speed of the vehicle? _____ MPH

If the other vehicle was moving at the time of the impact, was it: (PLEASE CIRCLE)

SLOWING DOWN GAINING SPEED TRAVELING AT THE STEADY RATE OF SPEED

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

_____
_____
_____
_____

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NOTICE OF DOCTOR'S LIEN

_____	_____
Attorney/Adjuster	Patient
_____	_____
Address	Date of Birth
_____	_____
City, State, Zip Code	Address
	_____
	City, State, Zip Code

I do hereby, authorize **Chiropractic Del Sol** to furnish you, my Attorney/Adjuster, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself, in regard to the accident in which I was recently involved. I hereby authorize and direct you, my Attorney/Adjuster, to pay directly to said doctor, such sums as may be due and owed to him for medical service rendered me, both by reason of this accident, and to withhold such sums form any settlement, judgment or verdicts as may be necessary to adequately protect said doctor. Also, 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/Adjuster, or myself, as the result of the injuries for which I have been treated or injuries in connection therein.

I agree never to rescind this document, and that a rescission will not be honored by my Attorney/Adjuster. I hereby instruct that in the event another Attorney/Adjuster is substituted in this matter, the new Attorney/Adjuster will honor this Lien as inherent to the settlement and enforceable upon the case, as if it were executed by themselves.

I fully understand that I am directly and fully responsible to said doctor, for all medical bills submitted by him for service rendered to me, and that this agreement is make solely for said doctor's additional protection, and in consideration of his awaiting payment. Furthermore, I 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 the doctor's office. I have been advised that if my Attorney/Adjuster does not wish to cooperate in protection of the doctor's interest, the said doctor will not await payment, but may declare the entire balance due and payable.

_____	_____
Date	Patient's Signature

The undersigned being Attorney/Adjuster of record, for the above patient, does hereby agree to observe all the 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/Adjuster further agrees that in the event this Lien is litigated, the prevailing party will be awarded attorney fees and cost.

_____	_____
Date	Attorney/Adjuster Signature