WORKERS COMP & AUTO INFORMATION

Please take a moment to fill out all the information below. Thank you!

Workers Compensation Information

Employer Name_____

Workers Compensation Insurance Company Name_____

Group #_____**Policy #**_____

Insurance Street Address _____

City, State, Zip _____

Insurance Phone_____**Insurance Fax**_____

Auto Insurance Information ***(Please present a copy of your insurance card)***

Name of Insured Person_____

Insurance Company_____**Effective Date**_____

Group #_____**Policy #**_____

Insurance Street Address _____

City, State, Zip _____

Insurance Phone_____**Max Annual Benefit**_____

Attorneys Contact Information (*Please ask us about our preferred list should you require one*)

Name of Attorney _____**Attorney's Assistant**__

Attorney's Office Name___

Street Address _____

City, State, Zip_____

Attorney's Phone #_____**Attorney's Fax #**_____

Financial Agreement

I, _____, patient of Smith Chiropractic & Wellness Center LLC hereby state: I acknowledge, pursuant to ORS 87.555(1) that Smith Chiropractic & Wellness Center LLC has a lien upon any money due or owing or any claim for compensation, damages, contribution, settlement, award or judgment from any person alleged to have caused the injuries and any other person liable for the injury or obligated to compensate the injured person on account of the injuries. This lien applies to any person or insurer that provides for payment for hospitalization services or medical treatment rendered to the injured person, including an insurer that provides personal injury protection coverage or similar no-fault medical insurance. The hospitalization services or medical treatment was rendered to the injured person began this day and the lien shall be in place until final treatment has been received. In the event that benefits exhaust or are denied by the auto or workers compensation carrier, I acknowledge that I'm responsible for all outstanding bills.

Patient Name	Patients Signature	Date

Guardian's Name	Guardian's Signature	Date

THE MOTOR VEHICLE COLLISION

Please take a moment to fill out all the information below if it pertains to your accident. Thank you!

Date of motor vehicle collision_____**Time of motor vehicle collision**_____

City and street (location) of collision_____**Who owns the vehicle you were in**_____

What is the estimated repair damage to the vehicle?_____ **□ Unknown at this time**

Did the police come to the accident? **□ Yes** **□ No**

Did the police make a written report? **□ Yes** **□ No** ***(If yes, Please provide a copy of the report for our records)***

Were you under the influence of alcohol at the time of impact? **□ Yes** **□ No** **Explain**_____

Were you under the influence of drugs at the time of impact? **□ Yes** **□ No** **Explain**_____

Were any photographs taken of the vehicle and accident? **□ Yes** **□ No** **If yes, who took them?**_____

Weather conditions at time of collision_____

Make, Model, Year of vehicle_____

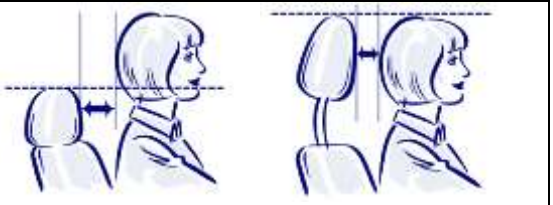
Size of vehicle: **□ Small** **□ Medium** **□ Large**

Were you the: **□ Driver** **□ Passenger**

Were you: **□ Rear-ended** **□ Hit head-on** **□ in a rollover** **□ T-boned**

□ Other_____

Circle or draw headrest position on impact



Did you have the seat belt on during impact? **□ Yes** **□ No**

Did your seat belt have a shoulder strap? **□ Yes** **□ No**

Did the seat belt engage on impact? **□ Yes** **□ No**

Were the brakes on when impacted? **□ Yes** **□ No**

Did you know you were going to be hit? **□ Yes** **□ No**

Did your air bag engage? **□ Yes** **□ No**

At time of impact, were you **□ Slowing down** **□ Gaining speed** **□ Stopped** **□ Moving at a steady speed**

Was the other vehicle **□ Slowing down** **□ Gaining speed** **□ Stopped** **□ Moving at a steady speed**

How fast were you traveling?_____**How fast was the other vehicle traveling?**_____

Were you breaking your vehicle at the time of impact? **□ Yes** **□ No**

Were they breaking their vehicle at the time of impact? **□ Yes** **□ No**

Did you hit? **□ A Pedestrian** **□ Another vehicle** **□ Tree** **□ Other**_____

Did you brace your **□ Hands** **□ Feet** **□ Entire Body**

Did you have your feet or foot braced on the **□ Floor Board** **□ Brake**

Did you have both hands on the steering wheel at the time of impact? **□ Yes** **□ No**

Were your arms locked and bracing at the time of impact? **□ Yes** **□ No**

Were you leaning <u>forward</u> at the time of impact? **□ Yes** **□ No**

Did your glasses end up in the backseat or floor? **□ Yes** **□ No**

Were you leaning to <u>one side</u> during impact? **□ Yes** **□ No** **If yes: to the >** **□ Left** **□ Right**

Was your <u>head</u> turned at the time of impact? **□ Yes** **□ No** **If yes: to the >** **□ Left** **□ Right**

Was your <u>body</u> turned at the time of impact? **□ Yes** **□ No** **If yes: to the >** **□ Left** **□ Right**

Did your <u>head</u> hit the **□ Dash** **□ Steering wheel** **□ Window** **□ Door** **□ Ceiling** **□ Other** _____

Did your <u>body</u> hit the **□ Dash** **□ Steering wheel** **□ Window** **□ Door** **□ Ceiling** **□ Other** _____

Did your <u>knees</u> hit the dash? **□ Yes** **□ No**

NARRATIVE OF ACCIDENT

Please describe the damages the vehicle (if any) you were operating.

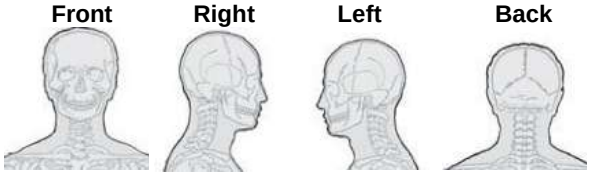
Please describe the events of the accident as you recall them. Be sure to include as much detail as needed.

HEAD/NECK INJURY

Please take a moment to fill out all the information below if it pertains to your accident. Thank you!

SHADE LOCATION OF HEADACHE PAIN

Front **Right** **Left** **Back**



Do you recall hitting your head? □ Yes □ No (If yes on what?)_____

Does your head hurt? □ Yes □ No (If yes where?)_____

Do you have a headache? □ Yes □ No (If yes, is it?) □ Constant □ Come and go

Is your headache □ Sharp □ Stabbing □ Throbbing □ Dull □ Achy □ Other_____

Do you have accompanying □ Dizziness □ Face numbness □ Jaw pain

Are you ear(s) □ Ringing □ Roaring □ Buzzing (if so, is it from the accident?) □ Yes □ No

Are you experiencing □ Blurred vision □ Double vision (if so, is it from the accident?) □ Yes □ No

CONCUSSION SCREENING

Please take a moment to fill out all the information below if it pertains to your accident. Thank you!

Did you lose consciousness? □ Yes □ No

If yes, what is the first thing you remember_____

CHECK ALL THAT APPLY							
	NONE	1	MILD 2	3	MOD 4	5	SEV 6
Headache	□	□	□	□	□	□	□
Pressure in the Head	□	□	□	□	□	□	□
Neck Pain	□	□	□	□	□	□	□
Nausea or Vomiting	□	□	□	□	□	□	□
Dizziness	□	□	□	□	□	□	□
Blurred Vision	□	□	□	□	□	□	□
Balance Problems	□	□	□	□	□	□	□
Sensitivity to Light	□	□	□	□	□	□	□
Sensitivity to Noise	□	□	□	□	□	□	□
Feeling Slowed Down	□	□	□	□	□	□	□
Feeling Like Your "In a Fog"	□	□	□	□	□	□	□
"Don't Feel Right"	□	□	□	□	□	□	□
Difficulty Concentrating	□	□	□	□	□	□	□
Difficulty Remembering	□	□	□	□	□	□	□
Fatigue or Low Engery	□	□	□	□	□	□	□
Confusion	□	□	□	□	□	□	□
Drowsiness	□	□	□	□	□	□	□
Trouble Falling Asleep	□	□	□	□	□	□	□
More Emotional	□	□	□	□	□	□	□
Irritability	□	□	□	□	□	□	□
Sadness	□	□	□	□	□	□	□
Nervous or Anxious	□	□	□	□	□	□	□

Approximately how long were you unconscious □ Not at all □ Less than 30 mins □ More than 30 mins