PATHWAYS
CHIROPRACTIC HEALTH CENTER

16154 Main Ave SE, Prior Lake, MN 55372
Phone (952)447-3000 Fax (952)447-3561

Name_____ Phone_____

Have you retained an attorney? □ Yes □ No	Attorney's Name:	Attorney's phone number:	
Attorney's Street Address:	City:	State:	Zip Code:

Auto Owner's Name:			Other Driver's Name		
Auto Owner's Insurance Carrier:			Other Driver's Insurance Carrier:		
Insurance Address:			Insurance Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Insurance phone number:			Insurance number:		
Claim #:	Policy #:		Claim #:	Policy #:	
If you were injured in an auto, indicate your status: □ Driver □ Passenger □ Other _____					

Patient Signature _____ Date _____

Please provide as much information as possible when completing this injury report.

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Auto Accident/Personal Injury Financial Policy

It is necessary for you to provide us with accurate and complete account/claim information. As a courtesy, we will submit charges to your insurance. **Ultimately, you are responsible for all charges incurred on your account.**

If you have health insurance benefits, you need to present your insurance card and a photocopy will be made and kept in your file for future submission once your med-pay limit on your auto insurance policy has been exhausted.

If we are submitting charges to your health insurance you will be expected to make payments according to the benefit information provided to our office. If you suspend or terminate care with our office, we reserve the right to request payment in full immediately regardless of any claims submitted. You will be expected to resolve your balance in full no more than 6 months after your doctor has discharged you from this case unless other arrangements have been made with our office.

If an attorney is representing you, please notify us immediately.

Patient Signature_____Date_____

Witness Signature_____ Date_____

PATHWAYS
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AUTO ACCIDENT/PERSONAL INJURY QUESTIONNAIRE

16154 Main Ave SE, Prior Lake, MN 55372 Phone (952)447-3000 Fax (952)447-3561

(Please fill out all information completely, indicate N/A if not applicable)

Name _____ Today's Date ____/_____/_____ Date of Accident ____/_____/_____

Please describe, to the best of your ability, what happened during this accident _____

_____

_____

_____

History of Occurrence

☐ Pedestrian ☐ Driver ☐ Passenger- Middle Front ☐ Passenger- Right Front
☐ Passenger- Left Rear ☐ Passenger- Center Rear ☐ Passenger -Right Rear

Patient Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____

Second Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____

Third Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____

Road Conditions
☐ Dry ☐ Icy ☐ Wet ☐ Clear ☐ Foggy ☐ Dark ☐ Other _____

Road Type
☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other _____

Were you aware the accident was going to occur? ☐ Yes ☐ No
Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, was it a: ☐ lap seatbelt ☐ shoulder-lap seatbelt
Did your airbag deploy? ☐ Yes ☐ No
Does your car have a head rest? ☐ Yes ☐ No
What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Was your car braking? ☐ Yes ☐ No. Was your car moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No. Was the second vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No. Was the third vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details

First Impact: ☐ Hit by another vehicle ☐ Hit another vehicle ☐ Hit by an object ☐ Hit an object
(on the) ☐ Front ☐ Front-Right ☐ Front-Left ☐ Left ☐ Right ☐ Right-Rear ☐ Left-Rear ☐ Rear ☐ Top

Second Impact: ☐ Hit by another vehicle ☐ Hit another vehicle ☐ Hit by an object ☐ Hit an object
(on the) ☐ Front ☐ Front-Right ☐ Front-Left ☐ Left ☐ Right ☐ Right-Rear ☐ Left-Rear ☐ Rear ☐ Top

Collision Results

Body was thrown: ☐ Backward ☐ Forward ☐ Left ☐ Right ☐ Can't Remember

Head Hit:	☐ Airbag	☐ Another person's body	☐ Back of front seat	☐ Dashboard
	☐ Front windshield	☐ Rear-view mirror	☐ Side window/door	☐ Steering wheel
	☐ Windshield			
Chest Hit:	☐ Another person's body	☐ Back of front seat	☐ Dashboard	☐ Side window/door
	☐ Steering wheel			
Shoulders Hit:	☐ Another person's body	☐ Back of front seat	☐ Shoulder harness	☐ Side window/door
Knees Hit:	☐ Another person's body	☐ Back of front seat	☐ Center console	☐ Dashboard
	☐ Door panel	☐ Steering wheel		
Hips Hit:	☐ Another person's body	☐ Back of front seat	☐ Center console	☐ Dashboard
	☐ Door panel	☐ Steering wheel		

Vehicle Damage

First Vehicle: ☐ Totaled ☐ Significant damage ☐ Light damage ☐ No damage
Second Vehicle: ☐ Totaled ☐ Significant damage ☐ Light damage ☐ No damage
Third Vehicle: ☐ Totaled ☐ Significant damage ☐ Light damage ☐ No damage

Were you hospitalized? ☐ Yes ☐ No If yes, please answer the questions in the paragraph below.

When were you hospitalized? Date _____ ☐ Immediately ☐ Later the same day ☐ The next day.
How were you transported to the hospital? ☐ Ambulance ☐ Air lifted ☐ Private transportation
What did the hospital recommend? ☐ No instructions ☐ See this clinic ☐ See DC ☐ See own Doctor
☐ See Neurologist ☐ See Orthopedist ☐ Over the counter medication ☐ Prescription medication
☐ Other _____
Did you have any x-rays taken? ☐ Yes ☐ No If yes, what areas? _____

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness ☐ Other_____
Did you have these symptoms prior to the injury? ☐ No ☐ Yes

Are you currently suffering from any of the following?

☐ Restlessness	☐ Irritability
☐ Difficulty sleeping	☐ Difficulty with memory
☐ Sleeplessness	☐ Forgetfulness
☐ Reduced tolerance to heat	☐ Reduced tolerance to alcohol

Did you lose consciousness (black out) upon impact? ☐ No ☐ Yes If yes, how long?_____

What bleeding cuts did you sustain during the accident? _____

What bruises did you sustain during the accident? _____

Any other comments?_____

_____

_____

Patient Signature_____ Date_____

CA Signature _____ Date _____