VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

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

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

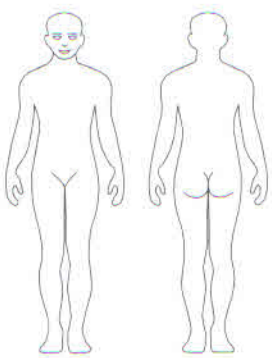
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

LIEN ON PERSONAL INJURY RECOVERY

This agreement is entered in between Champlain Chiropractic Clinic (hereinafter "Provider"), and _____ (hereinafter "Patient"), in consideration of the obligations set forth herein and established certain obligations and responsibilities relating to Patient's accident of _____ 20 _____. (hereinafter "claim.")

1. Patient herby gives a lien to Provider against all proceeds derived from this claim (whether by settlement, judgment, or otherwise) to secure payment of all fees owed to Provider by Patient for health care services and supplies arising out of injuries sustained, as of the time such proceeds are paid. This lien shall have priority over any subsequent lien or assignment of patient's interest. Patient hereby directs patient's attorney and all responsible parties to pay such sums as are secured hereby directly to provider, as soon as possible after any proceeds are received. Patient authorizes the patient attorney(s) to release to the Provider all information relating to any settlement received or to be received an any proposed disbursements there from.

2. Patient hereby expressly recognizes that even though this lien has been given, Patient still remains personally responsible for Provider's fees and that payment of such fees must be made by patient regardless of whether any money is received through patient's personal injury claim.

3. Patient hereby authorizes Provider to furnish Attorney, at reasonable intervals upon Attorney's request, complete reports of patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within reasonable time, and at a reasonable cost.

4. Provider hereby agrees to await Patient's payment of provider's fees until claim is concluded, except to the extent that payment is available from insurance which provides health care benefits for Patient. Provider agrees to be available to Patient's attorney, upon reasonable notice and for reasonable compensation for consultations, depositions and court appearances. In the event Provider is requested or subpoenaed to testify, Provider shall be entitled to reasonable compensation as an expert witness.

5. In the event of any dispute between the Provider and the Patient concerning Provider's fees, Attorney shall hold in trust until such dispute is resolved, or to deposit with the Court, a sufficient amount of Patients proceeds to satisfy Provider's claimed fee.

6. Patient hereby agrees to notify Provider, immediately, should Patient retain new legal counsel. Patient agrees to direct new legal counsel to execute another copy of this Claim Agreement and Lien when in is furnished by Provider. Should new legal counsel fail or refuse to execute another copy of this lien agreement, within ten days after being provided a copy, then patient's bill shall become immediately due and payable in full.

7. Should any party seek judicial enforcement of this agreement, the prevailing party shall be entitled to reasonable attorney fees.

8. This claim Agreement and Lien cannot be modified, changed, or revoked by any party without the express written consent of all parties.

9. A faxed signature on this lien shall be effective as an original signature.

_____ _____
Patient Date

_____ _____
Provider Date

The undersigned Attorney acknowledges receipt of a copy of this lien and agrees to be bound hereby.

_____ _____
Attorney Date