1601-A William Way
Mount Vernon, WA 98273
(360) 424-8115

Northwest Chiropractic Clinic, P.S.
Mechanism of Injury Questionnaire

Personal Information

Name _____ Date _____
Street Address _____
City/State/Zip _____
E-Mail Address (optional) _____SSN_____
(H) Phone (_____) _____ - _____ (W) Phone (_____) _____ - _____
Cell Phone (_____) _____ - _____ Fax (_____) _____ - _____
Birth date _____ / _____ / _____ Age _____ Sex M ____ F____
Name of Employer _____ Occupation _____

Marital Status Single _____ Married _____ Divorced _____ Widowed _____
Name of Spouse/Significant other (if applicable) _____
Name of Spouse/Significant other employer _____
Work phone (_____) _____ - _____ Cell phone (_____) _____ - _____
Children Yes ____ No ____ If yes, how many _____ SS# _____-_____-_____
Who referred you to our office _____

Emergency Contact Information

Name _____ Relation _____
Day Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Insurance Information

Health Insurance

Name of insurance company _____

Policy holder's name _____ Policy number _____

Employer _____ SS# _____

Automobile Insurance

Name of insurance company _____

Agent's name _____ Phone number _____

Policy holder's name _____ Policy number _____

Claim number _____ PIP coverage ☐ Yes ☐ No

The following questions pertain to the other vehicle involved in the accident:

Name of Driver_____ Phone # _____
Address_____ Ins Company_____
Agent's name_____ Phone # _____

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Name _____ DOB _____/_____/_____

Date of Collision ________ Time _____

Place _____

Intersecting with _____

Police Investigation by ☐ Washington State Patrol ☐ _____ City Police
☐ _____ County Police ☐ No investigation

Were there any witnesses? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No
If yes, whom? _____
_____
Phone number ( ) _____-_____

Please describe, to the best of your knowledge, what happened during this collision.

_____
_____
_____
_____

What is the last thing you remember before the collision? _____
_____

What is the next thing you remember after the collision? _____
_____

What type of car were you in? (year, make, and model)_____

What did your vehicle impact?
☐ Another vehicle (year, make, model) _____
☐ Other – explain _____

Road conditions at time of accident ☐ Wet ☐ Dry ☐ Icy
☐ Other - Describe _____

Where were you seated in the vehicle? ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Were you wearing a seat belt? ☐ Yes ☐ No
If yes, what type? ☐ Lap belt only ☐ Shoulder and lap belt

Did you have any bruising or tenderness on your body in the area of the seatbelt following the collision?
☐ Yes ☐ No If yes, please describe _____

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Name _____ DOB _____/_____/_____

Were you ☐ Aware of the approaching collision prior to impact
☐ Surprised by the impact

Was your vehicle equipped with headrests? ☐ Yes ☐ No
If yes, was the top of the headrest
☐ Above the base of your skull ☐ Below the base of your skull
Was the headrest altered or damaged in the collision? ☐ Yes ☐ No
Did your head go back over the top of the headrest? ☐ Yes ☐ No ☐ Unsure

Is your car equipped with an air bag? ☐ Yes ☐ No
If yes, did the air bag activate? ☐ Yes ☐ No
If yes, did you receive any injury from the airbag? ☐ Yes ☐ No,
If yes, please describe _____

Did the impact to your vehicle come from the
☐ Front ☐ Rear ☐ Right side ☐ Left side ☐ Other _____

Was your car stopped at the time of impact? ☐ Yes ☐ No
If yes, was the driver's foot on the brake? ☐ Yes ☐ No ☐ Don't know
If your foot was on the brake, was it pressing down? ☐ Slightly ☐ Moderately ☐ Strongly
If no, what was the approximate speed of your vehicle? _____ mph

If your vehicle was moving at the time of impact, was it
☐ Slowing down ☐ Gaining speed ☐ Steady speed

Was your vehicle pushed forward from the impact? ☐ Yes ☐ No
If yes, how much?
☐ More than one car length ☐ One car length
☐ One-half car length ☐ Less than one-half car length
☐ Not at all

Did your car hit anything else after the first impact? ☐ Yes ☐ No
If yes, please describe _____

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

Which of the following car parts broke during the accident?
a. Windshield _____ d. Front seat back _____
b. Right/Left side window _____ e. Other _____
c. Steering wheel _____ f. Other _____

Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No
If yes, what was its approximate speed? Approximately _____ mph

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Name _____ DOB _____/_____/_____

If the other vehicle was moving at the time of collision, was it
☐ Slowing down ☐ Gaining speed ☐ Steady speed

What direction was your head pointed at the time of the collision?

☐ Right ☐ Left ☐ Forward

What was the position of your hands at the time of the collision? _____

What was the position of your legs at the time of the collision? _____

Were you wearing a hat or eyeglasses at the time of the collision? ☐ Yes ☐ No
If yes, did they stay on? ☐ Yes ☐ No
If no, where did they land? _____

What bruises or cuts did you get from this collision?_____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
A. Head hit _____
B. Chest hit _____
C. Right shoulder hit_____ Left shoulder hit _____
D. Right arm hit _____ Left arm hit _____
E. Right hip hit _____ Left hip hit _____
F. Right leg hit _____ Left leg hit _____
G. Right knee hit _____ Left knee hit _____
H. Other _____
_____
_____

When did you first notice pain or symptoms?_____

Please describe how you felt immediately after the collision. _____
_____
_____
_____

Did the collision render you unconscious? ☐ Yes ☐ No ☐ Don't know
If yes, for how long? _____

Have you gone to a hospital? ☐ Yes ☐ No Hospital _____
If yes, when did you go? _____
How did you get there? _____
What parts of your body were x-rayed? _____ ☐ None
What treatment did you receive? _____

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Name _____ DOB _____/_____/_____

Have you been treated by any other doctor or health professional? ☐ Yes ☐ No If yes, when? _____
If yes, Date treated_____ Name_____ City _____
Recommendation and or treatment received_____
_____

How long were you treated? ☐ One time ☐ Other _____

Have you taken any medications for your injuries? ☐ Yes ☐ No
If yes, are what are you taking? _____
Are you still taking them? ☐ Yes ☐ No
Do they help? ☐ Yes ☐ No ☐ Don't know
If no, how long did you take them? _____
Why did you quit? _____

Have you lost time from work as a result of this injury? ☐ Yes ☐ No
If yes, give dates _____

Are your work, home or recreational activities restricted as a result of this injury? ☐ Yes ☐ No
If yes, describe restrictions _____
_____

Indicate the symptoms that are a result of this collision

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/shoulder pain	☐ Low back pain
☐ Headaches	☐ Fatigue	☐ Numb hands/fingers	☐ Low back stiffness
☐ Blurred vision	☐ Tension	☐ Right ☐ Left ☐ Both	☐ Leg pain
☐ Buzzing in ear	☐ Depression	☐ Mid back pain	☐ Right ☐ Left
☐ Ringing in ear	☐ Neck pain	☐ Chest pain	☐ Numb feet/toes
☐ Loss of balance	☐ Neck stiffness	☐ Stomach upset	☐ Right ☐ Left

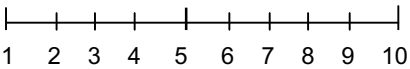
☐ Other _____

Is your condition ☐ improved ☐ unchanged ☐ getting worse ☐ constant ☐ comes and goes

Your Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Medications	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Fruits/Vegetables	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Stress	☐	☐	☐	☐

Sleep Average Hours per night



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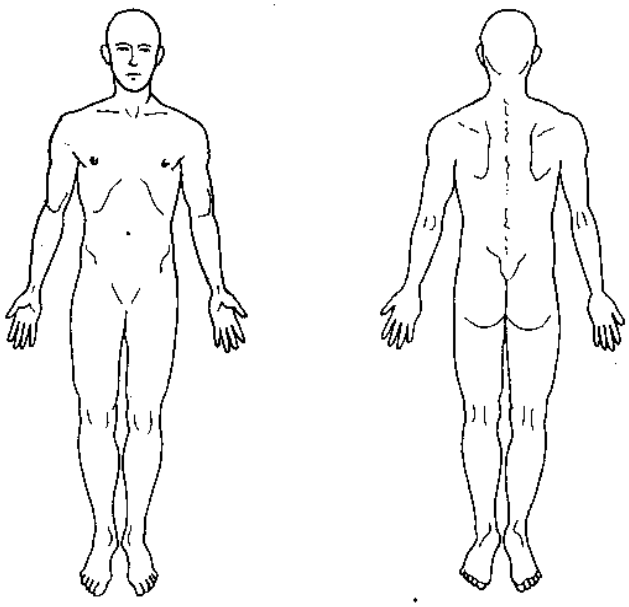
Miscellaneous

Drugs or Medication(s) you take
☐ Sleeping Pills ☐ Antidepressants ☐Blood Pressure ☐ Cholesterol
☐ Birth Control ☐ Other _____
Do you take nutritional Supplements? If so, please list _____
Age of Mattress _____ ☐ Comfortable ☐ Uncomfortable
Are you wearing ☐ Heel Lifts ☐ Sole Lifts ☐ Arch Support/Orthotic

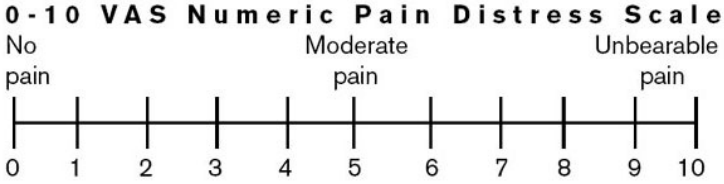
Symptom Pattern Diagram

Symptom Pattern Diagram
Please read carefully:
Mark the areas on your body where you feel your symptoms. Include all affected areas. Mark areas of radiation. If your symptom radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the symptom travel. Use the appropriate symbol(s) listed.

Ache:	**A**
Numbness:	**N**
Pins & Needles:	**PN**
Burning:	**B**
Stabbing:	**S**
Throbbing:	**T**
Other: _____	



0-10 VAS Numeric Pain Distress Scale



Using the scale to the above, grade your pain

Headache	_____
Neck pain	_____
Mid back pain	_____
Low back pain	_____
Arm/shoulder pain	_____
Leg pain	_____
Other_____	_____

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Consent to X-Ray – Female Patients and Children under the age of 18

This is to certify that to the best of my knowledge I am not pregnant and that Northwest Chiropractic, PS has my permission to take x-rays of me.

Patient Signature _____

Today's Date _____ Date of Last Menses _____

I hereby give my consent to Northwest Chiropractic, PS to examine, x-ray, and treat my child of ward.

Patient's Name _____

Guardian's Signature _____ Date _____

Patient Agreement

Reminder Your insurance is an agreement between you and your insurance. You must clearly understand and agree that for all services rendered to you in our office, you will be charged directly and you are personally responsible. As a courtesy to our patients, our office will submit your insurance claims in a timely manner at no charge to you.

By signing below, I permit Northwest Chiropractic, PS to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered are charged directly to my account and that I am personally responsible for payment. It is my understanding that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors of Northwest Chiropractic, PS, and whomever they may designate as their assistants, to administer treatment as they so deem necessary. I also authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

I understand that the above information and statements made on this form are accurate to the best of my knowledge, and I understand it is my responsibility to inform the office of any future changes in medical status.

Signature _____ Date _____

Parent or Guardian's Signature _____