

**Buckingham Chiropractic, PLLC**  
**8430 Rea Rd Ste. C**  
**Charlotte, NC 28277**  
**980-262-4457**

**Automobile Accident Questionnaire**

Accident Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Date of Accident: \_\_\_\_\_ Time: a.m./p.m.

2. Driver of car: \_\_\_\_\_ Where you were seated: \_\_\_\_\_

3. Owner of car: \_\_\_\_\_ Year and Model of car: \_\_\_\_\_

4. Visibility at time of accident: poor/fair/good/other:

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other:

6. Where was your car struck? right/left/rear/front/side/other:

7. Type of accident:  head-on collision  broad-side collision  rear-end collision  front impact, rear-ended car in front  
 non-collision:

8. What part of the car was damaged? \_\_\_\_\_

9. Describe what happened to you upon impact? \_\_\_\_\_

10. Did you see the accident was about to happen?  Yes  No

11. Did you brace for impact?  Yes  No

12. Were you wearing a seatbelt?  Yes  No

16. Was your car braking?  Yes  No      Was the other car braking?  Yes  No

17. Was your car moving at the time of the accident?  Yes  No

If yes, how fast would you estimate you were going? \_\_\_\_\_

18. How fast would you estimate the other car was traveling? \_\_\_\_\_

19. What was the position of your head and body at the time of impact?

head turned left/right  body straight in sitting position  head looking back

body rotated left/right  head straight forward  other: \_\_\_\_\_

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:  
\_\_\_\_\_

21. As a result of the accident were you:  rendered unconscious  dazed  other:

22. Could you move all parts of your body?  yes  no

If no, why not? \_\_\_\_\_

23. Were you able to get out of the car and walk unaided?  yes  no

If no, why not? \_\_\_\_\_

24. Did you have any cuts or bruises from this accident?  yes  no

If so, where? \_\_\_\_\_

25. Describe how you felt immediately after the accident? \_\_\_\_\_

How did you feel later that  day  night?

How did you feel the next day(s)? \_\_\_\_\_

26. Check symptoms apparent since the accident:

headache  loss of smell  numbness in fingers  neck pain/stiffness

loss of taste  cold hands  mid-back pain  loss of memory

cold feet  low-back pain  fatigue  diarrhea

tension  constipation  pain behind eyes  shortness of breath

chest pain  dizziness  irritability  nervousness

fainting  depression  cold sweats  anxious

sleeping problems  loss of balance  numbness in toes

ringing/buzzing in ears  eyes sensitive to light  other: \_\_\_\_\_

27. Have you missed time from work?  yes  no      Work hours are:  full-time  part-time

If you have missed time from work, how much time have you missed? \_\_\_\_\_

28. Did you seek medical help immediately/soon after the accident?  yes  no      If no, skip to #35

If yes, how did you get there? \_\_\_\_\_

29. Doctor/hospital/clinic seen: \_\_\_\_\_ Date: \_\_\_\_\_

30. What was done? \_\_\_\_\_

Were x-rays taken?  yes  no      If yes, of what body part? \_\_\_\_\_

31. What treatments/prescriptions were given?  bed rest  brace  adjustments  medications

32. What benefit(s) did you receive from treatment(s)? \_\_\_\_\_

33. Date of last treatment: \_\_\_\_\_

34. Are any of your activities of daily living any different now compared to before the accident?

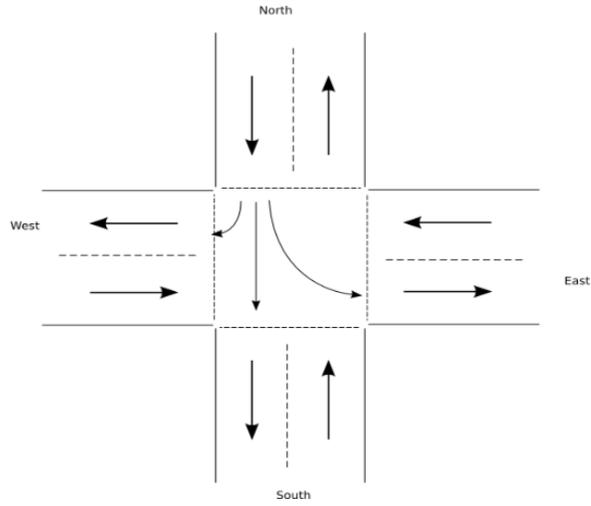
yes  no

List anything you are unable to do: \_\_\_\_\_

List anything that is painful to do: \_\_\_\_\_

List anything that is difficult to do: \_\_\_\_\_

35. Indicate on the diagram below how the accident happened:



Comments: \_\_\_\_\_

36. Do you have an attorney handling this case?  yes  no

If yes, who? (name/address/phone number)

\_\_\_\_\_

**To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:**

**ASSIGNMENT OF BENEFITS**

IN CONSIDERATION of the willingness of Buckingham Chiropractic to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Buckingham Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on \_\_\_\_\_ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Buckingham Chiropractic, PLLC from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Buckingham Chiropractic, PLLC for its services rendered.

I appoint Buckingham Chiropractic, PLLC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Buckingham Chiropractic, PLLC.

I authorize Buckingham Chiropractic, PLLC to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Buckingham Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Buckingham Chiropractic, PLLC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Buckingham Chiropractic, PLLC for its costs of recovery, including reasonable attorney's fees.

**NOTICE OF LIEN**

Pursuant to N.C.G.S. 44-49 and 44-50, Buckingham Chiropractic, PLLC hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Buckingham Chiropractic, PLLC hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S 44-50.1. Buckingham Chiropractic, PLLC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Buckingham Chiropractic, PLLC

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Buckingham Chiropractic, PLLC

**Check List for Personal Injury- To accept your personal injury case we need the following:**

- Attorney's name \_\_\_\_\_  
Phone \_\_\_\_\_
- A copy of the Police Report or Exchange Slip
- Liability Information (Responsible parties insurance)  
Insurance Company \_\_\_\_\_  
Claim # \_\_\_\_\_  
Policy # \_\_\_\_\_  
Phone # \_\_\_\_\_
- Your Personal Auto Insurance Company  
Insurance Company \_\_\_\_\_  
Claim # \_\_\_\_\_  
Policy # \_\_\_\_\_  
Phone # \_\_\_\_\_
- Records/ X-rays from any other doctor seen for this accident  
Doctor's Name \_\_\_\_\_  
Doctor's Office/Hospital \_\_\_\_\_

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**PLEASE INITIAL YOUR SELECTION**

\_\_\_\_\_ I wish to pay my own bill for treatment and be reimbursed by the insurance company.

\_\_\_\_\_ I wish **for Buckingham Chiropractic** to extend me credit for services rendered and accept assignment to be reimbursed by the insurance listed above.

\_\_\_\_\_ I choose to have an attorney to handle my case and have all of my bills sent to him/her.

\_\_\_\_\_ I choose to have an insurance adjuster to handle my claim and all my bills sent to him/her.

I understand that if I do not complete the above information, I will be held responsible for payments of services rendered at Buckingham Chiropractic. I also understand that if I do not receive compensation from a liability source that I am responsible for payment in full to our office.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Front Desk \_\_\_\_\_ Date: \_\_\_\_\_