



2105 E. Clairemont Avenue, Eau Claire, WI 54701 · Phone: (715) 835-9514 · Fax: (715) 835-2602

Name _____ Phone _____

Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Other _____					

Patient Signature _____ Date _____

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



Stucky Chiropractic
2105 E. Clairemont Avenue
Eau Claire, WI 54701
Phone: (715)835-9514
Fax: (715)835-2602

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.

We require a minimum \$50.00 co-payment for your initial visit and \$10.00 co-payment on all subsequent visits. 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 _____



PERSONAL INJURY/AUTO ACCIDENT QUESTIONNAIRE

2105 E. Clairemont Avenue, Eau Claire, WI 54701 * Phone (715)835-9514 * Fax (715)835-2602

(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 _____