Mechanism of Injury Questionnaire

Name:_____

Date of Collision:_____Time:_____

Place:_____

Intersecting with:_____

Police Investigation by: (Please give a copy of report to the front desk staff.)

[ ]Washington State Patrol [ ] _____City Police
[ ] _____County Police [ ] No Investigation

Road Conditions at time of accident: [ ] Wet [ ] Dry [ ] Icy

[ ] Other ---Describe:_____

Where were you seated in vehicle?_____

Were you aware of the approaching collision prior to impact of did the impact catch you by surprise?
[ ] Aware [ ] Surprise

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

_____

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

_____

Was the vehicle equipped with headrest? [ ] Yes [ ] No

How far is the top of the headrest from the top of your head?
Approximately_____inches above Approximately_____inches below

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

Where were you struck?
[ ] Behind [ ] Front [ ] Driver side [ ] Passenger side [ ] Other_____

Were you wearing a seat belt? [ ] Yes [ ] No
If so, what type? [ ] Lap belt only [ ] Shoulder and lap belt

Did you have any bruising or tenderness on your body in the area of the seat belt following the collision?
[ ] Yes [ ] No Please describe:_____

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_____

Was your car stopped at the time of the impact? [ ] Yes [ ] No
If no, then estimate the speed of the vehicle you were in: _____mph
If yes, was the driver's foot on the brake? [ ] Yes [ ] No
If your foot was on the brake, was it pressing down [ ] Slightly [ ] Moderately [ ] Strongly

If your vehicle was moving at the time of impact, was it slowing down? [ ] Yes [ ] No
If no, was your vehicle accelerating speed? [ ] Yes [ ] No
Was it traveling at a steady rate of speed at the time of impact? [ ] Yes [ ] No _____mph

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

How were your hands positioned at the time of the collision?_____

Were you wearing a hat or glasses at the time of the collision? [ ] Yes [ ] No

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

_____

_____

_____

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

What type of car impacted with your vehicle? (Year, make and model)_____

Was the other vehicle moving at the time of the collision? [ ] Yes [ ] No
If yes, what was its approximate speed? Approximately_____mph

If the other vehicle was moving at the time of the collision, was it:
[ ] Slowing down [ ] Gaining speed [ ] Steady speed?

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

On what part of the automobile did the following body parts hit:

A. Head hit	[ ]
B. Chest hit	[ ]
C. Right/left shoulder hit	[ ]
D. Right/left arm hit	[ ]
E. Right/left hip hit	[ ]
F. Right/left leg hit	[ ]
G. Right/left knee hit	[ ]
H. Other_____	[ ]

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 on first impact?_____

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

What of the following car parts broke during the collision?_____
[ ] Windshield [ ] Front seat back
[ ] Right/left side window [ ] Other_____
[ ] Steering Wheel [ ] Other_____

What hurts?_____

_____

When did you first notice your symptoms?_____

_____

Head Injury Questionnaire

Patient Name: _____

Did Your Head Hit Any Part of the Car?

Yes	No	
☐	☐	Windshield
☐	☐	Steering Wheel
☐	☐	Dashboard
☐	☐	Side Car Window
☐	☐	Other Passenger
☐	☐	Mirror
☐	☐	Other _____

What Part of Your Head Was Hit?

- ☐ Forehead
- ☐ Back of Head
- ☐ Left Side of Head
- ☐ Right Side of Head
- ☐ Top of Head
- ☐ Other _____

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

_____

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

_____

History

Yes	No	
☐	☐	Did you lose consciousness or black our for any time (seconds or minutes)?
☐	☐	Did you feel an altered state of awareness, dazed or confused?
☐	☐	Have you lost any memory of events prior to your head injury?
☐	☐	Has your memory been different since the head injury?
☐	☐	Did you have a lump or bruise on part of your head after the head injury? Where? _____
☐	☐	Have you had any head injuries in your past?
☐	☐	Have you had any x-rays taken?
☐	☐	Have you had a computed tomography (CT) or magnetic resonance imaging (MRI) scan take of your head?

Please check the following boxes that correspond to any symptoms that you have had since your neck or head injury.

Symptom

- ☐ Headaches
- ☐ Loss of Coordination
- ☐ Reduced Drive/Motivation
- ☐ Poor Memory
- ☐ Difficulty Finishing Tasks
- ☐ Sleep Disorders
- ☐ Abnormal Levels of Anxiety
- ☐ Reduced Tolerance to Alcohol
- ☐ More Assertive
- ☐ Forgetful
- ☐ Anger Outbursts
- ☐ Depression
- ☐ Fatigue
- ☐ Absence of Ability to Anticipate
- ☐ Inflexibility
- ☐ Impaired Sexual Function
- ☐ Language Difficulty
- ☐ Impaired Judgement
- ☐ Need Day-timer to Remember Home and/or Work Activities
- ☐ Blurry Vision
- ☐ Loss of Balance
- ☐ Difficulty Handling Multiple Tasks

Symptom

- ☐ Dizziness/Light-headedness
- ☐ Irritability
- ☐ Personality Change
- ☐ Hand Tremors
- ☐ Ringing in Ears
- ☐ Less Diplomatic Than Normal
- ☐ Mood Swings
- ☐ Reduced Attention Span
- ☐ Blackouts
- ☐ Indifference to Other People
- ☐ More Shallow Relationships
- ☐ Difficulty with Problem Solving
- ☐ Less Mental Stamina
- ☐ Performance Inconsistencies
- ☐ Verbal Learning Problems
- ☐ Slower Reaction Times

_____

Signature of patient

_____

Date

MURRY CHIROPRACTIC & Associates, PS
(360)734-9525
chiropractic • massage • acupuncture

MURRY CHIROPRACTIC
Financial Agreement & Policy

PERSONAL INJURY PROTECTION (PIP) CLAIMS

Patient Name_____Date of Injury_____

Claim#_____Insurance Co._____

Claims Adjuster_____Phone number_____

Fax _____ Email _____

I understand it is my responsibility to know the *funds available* on my Personal Injury Protection (PIP) policy throughout my treatment at Murry Chiropractic & Associates. In the event that I exceed my available funds, I understand I am ultimately responsible for any amount not paid by my insurance company. I understand that insurance policies are an arrangement between an insurance carrier and myself. I authorize payment of medical benefits to Murry Chiropractic & Associates, and my signature will act as authorization. I understand that this office will prepare any necessary insurance reports and forms on my behalf, but Murry Chiropractic & Associates, cannot be held responsible for lack of payment by my insurance company. If I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. ***Please allow 24 hours notice if you are unable to make your appointment. There will be a $50 fee for late/same-day cancellations or No-Show appointments.***

I have read, understand and agree to the above Financial Agreement & Policy.

Patient Signature_____Date_____