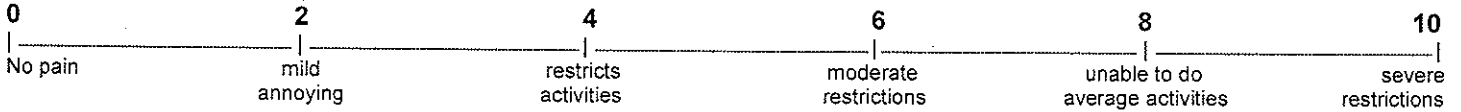


**Goodyear
Chiropractic**

11 W. Van Buren Avondale, AZ 85323
(623)932.4060 (623)932.4417 fax

Functional Questionnaire

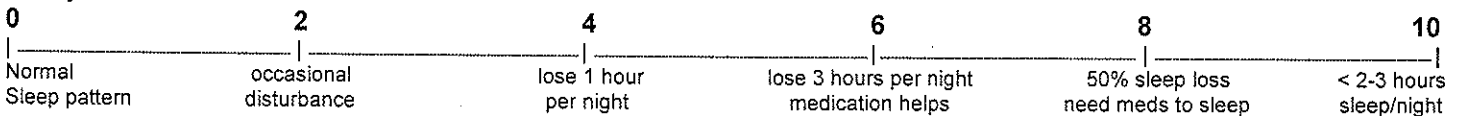
General Pain Intensity



Work Ability



Sleep



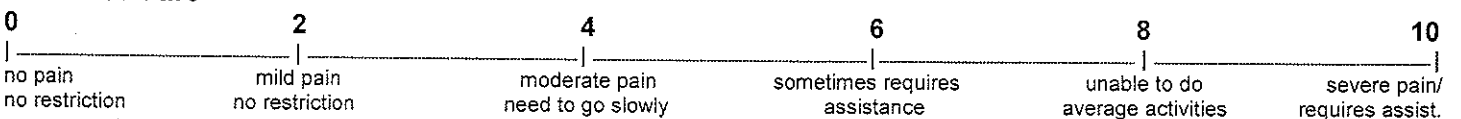
Social & Recreation



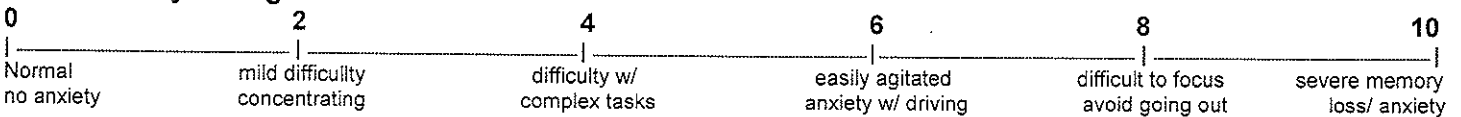
Travel



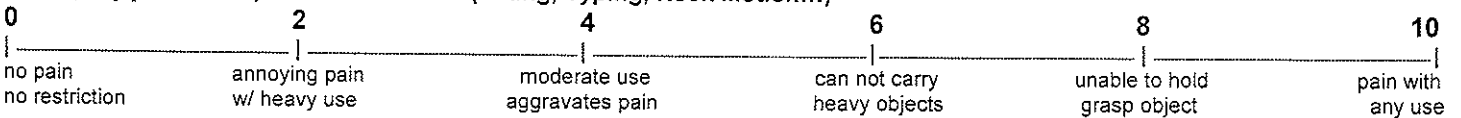
Personal Care



Mental & Psychological



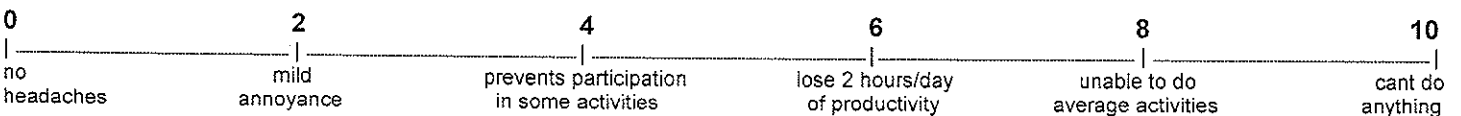
Neck, Upper Back, Arm Function (Lifting, Typing, Neck Motion...)



Low Back, Hip, Leg (Lifting, Sitting, Standing...)



Headache



Patient Signature _____ Date _____ File Number _____ Total Score _____

Goodyear Chiropractic

11 W. Van Buren St., Ste.28
Avondale, AZ 85323

Auto Accident Questionnaire

1. Check which vehicle-type you were in.
Car___ Truck___ Van___ SUV___ Bus___
Compact___ Mid-size___ Full-size___ Light___
2. Check where you were in the vehicle.
Driver___ Front Passenger___
Rear Passenger: Right___ Left___ Middle___
3. Was your vehicle stopped? No___ Yes___
If yes, why was it stopped?
Traffic Light___ Intersection___ Stop sign___
Traffic___ Pedestrian___ Parked___
Other_____
4. Was your vehicle slowing down? No___ Yes___
If yes, why was it slowing?
Traffic Light___ Intersection___ Stop sign___
Traffic___ Pedestrian___ Parked___
Turning___ Other_____
5. What damage did your vehicle sustain?
Minimal___ Moderate___ Extensive___ Totaled___
Unsure___ Other_____
6. Was there another car involved in the accident?
No___ Yes___ If yes, what type?
Car___ Truck___ Van___ SUV___ Bus___
Compact___ Mid-size___ Full-size___ Light___
7. How did this vehicle strike the car you were in?
Head On___ From Right___ From Left___
Rear Ended___ Side Swiped on Right___
Side Swiped on Left___ Other_____
8. How badly was this other car damaged?
Minimal___ Moderate___ Extensive___ Totaled___
Unsure___ Other_____
9. Was there a third vehicle involved in the accident?
No___ Yes___ If yes, what type?
Car___ Truck___ Van___ SUV___ Bus___
Compact___ Mid-size___ Full-size___ Light___
10. How did this vehicle strike the car you were in?
Head On___ From Right___ From Left___
Rear Ended___ Side Swiped on Right___
Side Swiped on Left___ Other_____
11. How badly was this third vehicle damaged?
Minimal___ Moderate___ Extensive___ Totaled___
Unsure___ Other_____
12. Did any other vehicles strike your car?

13. What were the conditions at the time of the accident?
Time: Day___ Dawn___ Dusk___ Night___
Road: Dry___ Wet___ Snow___ Ice___
Visibility: Good___ Fair___ Poor___ Other___
Other Factors: Sun light___ Dark___ Rain___
Snow___ Fog___ Traffic___ Other_____
14. Were you prepared for the impact?
Surprised___ Aware___ And Brace___
15. Was your foot on the brake when you were hit?
No___ Yes___ But then knocked off the pedal___
16. What type of seat belt were you wearing?
Shoulder-lap___ Lap___ Shoulder___ None___
17. Where was you headrest?
High___ Low___ Middle___ No headrest___
18. Did your air bags deploy?
Yes___ No___ Car had no airbags___
19. Position your body was in at the time of impact?
Straight___ Slouched___ Rotated:Left___ Right___
20. What direction was your body thrown?
Back then forward___ Forward then back___
Sideways___ Across vehicle___ Outside vehicle___
Don't recall___ Other_____
21. Position your head was in at the time of impact?
Straight___ Rotated: Left___ Right___ Other___
22. What motion was your head and neck sent into?
Back then forward___ Forward then back___
Sideways___ Don't recall___ Other_____
23. Connect the body part with the object it hit.

Head	Steering Wheel
Right Arm	Dash Board
Left Arm	Windshield
Chest	Right Side Door
Right Leg	Left Side Door
	Right Window
	Left Window
	Headrest
Other Body Part	Ceiling
	Other_____
24. Additional Information?

Patient (Guardian) Signature _____	Date _____	File Number _____
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**Goodyear
Chiropractic**

11 W. Van Buren St., Ste.28
Avondale, AZ 85323

Insurance Information

Date of Accident: _____ **Driver** _____ **Passenger** _____

Please provide as much information as possible so your case can be set up to your financial advantage. In the state of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment occurs. We only need to be paid once, so all overpayments will be reimbursed.

Health Insurance

Insured Name: _____

Insurance Company: _____

Phone: _____

ID# _____

Group# _____

Send Claims To: _____

I give permission for Goodyear Chiropractic to bill my Health Ins. _____ **Yes** _____ **No**

Medical Payment Coverage: On your automobile insurance or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med Pay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or was not your fault, to slamming your finger in the car door. Using this portion of the policy cannot raise your premium or affect your record in anyway. In fact, this is exactly why you pay for "Med Pay" on your insurance policy. (This information is printed on the "Proof of Insurance" card in automobile.

Claimant: _____

Policy Holders Name: _____

Insurance Company: _____

Phone# _____ Ext # _____

Policy # _____

Claim # _____

Adjuster: _____

Send Claims To: _____

I give permission for Goodyear Chiropractic to bill my Auto Ins/MedPay/PIP. _____ **Yes** _____ **No**

Third Party Liability: Insurance information for the person who was in the "Other Car", found on the accident report.

Accident Report: _____

Was Anyone Ticketed? _____ **YES** _____ **NO** **WHO:** _____

Driver's Name: _____

Policy Holder's Name: _____

Insurance Co. Name: _____

Phone # _____ Ext # _____

Policy # _____

Claim # _____

Adjuster: _____

Send Claims To: _____

I give permission for Goodyear Chiropractic to bill my Third Party. _____ **Yes** _____ **No**

Attorney Information:

Name: _____

Firm: _____

Contact Person: _____

Phone # _____ Ext # _____

Send Statement To: _____

Patient Name _____ Medical Record # _____