Northgate Chiropractic

11065 5th Avenue NE Suite E, Seattle, WA 98125 · (206) 367-2224 · northgatechiro.com

Motor Vehicle Accident History

Complete on screen or print clearly · Optional fields may be skipped unless needed for billing

Account # (office use) | Today's date | Date of accident

PATIENT INFORMATION

Legal last name | Legal first name | Middle

Preferred name | Pronouns (optional) | Date of birth

Gender identity (optional — respectful care only; never used to deny services)

☐ Woman ☐ Man ☐ Non-binary ☐ Prefer not to say

Self-describe | Title (Mx/Mr/Ms/Dr…)

Sex assigned at birth (optional — skip if not needed)

☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say

Relationship / household (optional)

☐ Married ☐ Partnered / domestic partner ☐ Single

☐ Widowed ☐ Divorced ☐ Prefer not to say

Street address | City | State | ZIP

Mobile phone | Home phone | Email

SSN (optional — only if required for insurance billing) | Occupation

Employer | Work phone

Emergency contact

Name | Relationship | Phone

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT)

Name | Relationship | Phone

Address | City | State | ZIP

INSURANCE AND WASHINGTON PIP

Washington Personal Injury Protection (PIP) may cover reasonable and necessary chiropractic care after a motor vehicle accident when coverage applies (RCW 48.22). Your auto insurer may still require a separate PIP application. Bring claim numbers and a police report if available.

Your auto insurance company | Policy #

PIP / med-pay claim # (if any) | Adjuster name / phone

Other / at-fault carrier (if known) | Claim #

Health insurance (if any) | Member / ID #

Attorney name (if represented) | Attorney phone

I will provide insurance cards / claim info to staff

☐ Yes, today ☐ Later / will send

ACCIDENT DETAILS

Date of accident | Time of day | City / area of accident

Road condition

☐ Dry ☐ Wet ☐ Icy / snow ☐ Other

2 Were you: ☐ Driver ☐ Passenger ☐ Pedestrian / cyclist / other

2b If in a vehicle, seat position: ☐ Front seat ☐ Back seat ☐ Other

3 Number of people in your vehicle

4 Were you wearing a seat belt? ☐ Yes ☐ No ☐ N/A

5 Lap belt only? ☐ Yes ☐ No ☐ N/A

5b Lap and shoulder harness? ☐ Yes ☐ No ☐ N/A

6 Direction you were headed:

☐ North ☐ South ☐ East ☐ West ☐ Unknown

6b On (street and city)

7 Direction of the other vehicle:

☐ North ☐ South ☐ East ☐ West ☐ Unknown / N/A

7b On (street and city)

IMPACT AND VEHICLES

8 You were struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side

8b Other combination — describe

9 Head position during the accident: ☐ Straight ahead ☐ Turned right ☐ Turned left

9b Other

10 Did any part of your body strike anything inside the vehicle? ☐ Yes ☐ No

10b If yes, explain

11 Did items become displaced in the vehicle? ☐ Yes ☐ No

11b If yes, describe

12 Approximate speeds (mph)

Your vehicle Other vehicle

13 Make / model

Your vehicle Other vehicle

14 Were the police notified? ☐ Yes ☐ No

If yes, please provide this office with a copy of the police / collision report when available.

15 In your own words, describe the accident

HOW YOU FELT AND CARE SO FAR

16 Any physical complaints BEFORE the accident? ☐ Yes ☐ No

16b If yes, describe in detail

17a How you felt DURING the accident

17b IMMEDIATELY AFTER

17c LATER THAT DAY

17d THE NEXT DAY

18 Were you knocked unconscious? ☐ Yes ☐ No

18b If yes, for how long?

19 Where were you taken after the accident?

20 Treated by another doctor since this accident? ☐ Yes ☐ No

20b Doctor name / address

20c Type of treatment received

CURRENT SYMPTOMS & FUNCTION

21 Did this accident occur while performing regular job duties? ☐ Yes ☐ No

22 How do you feel now? #1 problem or area of greatest pain

23 Rate pain (0 = none, 10 = worst). Check one, or two for a range:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

24 Since this injury, is your pain: ☐ Improving ☐ Getting worse ☐ Staying the same

25. How often do you experience the pain?

☐ 1–2 hours per day ☐ About half the day

☐ Most of the day ☐ Never goes away

26. How does the pain affect daily activities?

☐ Does not affect activities ☐ Changed how I do things

☐ Stopped some activities ☐ Unable to perform daily activities

27 What increases your pain?

28 What decreases your pain?

29 Have you experienced this problem before? ☐ Yes ☐ No

29b When?

30 Previous illness or condition affecting present condition? ☐ Yes ☐ No

30b If yes, describe

31. Other current complaints — describe each, then check a 0–10 rating:

a. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

b. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

c. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

d. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

32 Lost time from work due to this accident? ☐ Yes ☐ No

Type of employment Last day worked

33 Involved in an accident before? ☐ Yes ☐ No

33a If yes, when?

33b Describe the accident(s)

33c Were you injured in prior accident(s)? ☐ Yes ☐ No

33d Explain

34 List all medications you currently take (prescribed and OTC)

35 List all surgeries (with approximate dates)

Pain regions (optional) — e.g. neck R, low back L, right shoulder:

HEALTH HISTORY CHECKLIST

Mark P = past condition, C = currently experiencing. Answer only as comfortable. This supports clinical safety — not a diagnosis.

P	C	Condition
☐	☐	Heart attack / heart disease
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Fainting spells
☐	☐	Difficulty with urination
☐	☐	Difficulty with bowel movements
☐	☐	Cancer
☐	☐	HIV
☐	☐	Diverticulosis
☐	☐	Dizziness
☐	☐	Chest pain
☐	☐	Constipation
☐	☐	General fatigue
☐	☐	Nausea
☐	☐	Soreness in joints
☐	☐	Ears ringing (tinnitus)
☐	☐	Migraine
☐	☐	Gout
☐	☐	STI (note details if needed)
☐	☐	Broken bones
☐	☐	Sprained ankle — left
☐	☐	Blood clots / DVT

P	C	Condition
☐	☐	Stroke / TIA
☐	☐	Gallbladder trouble
☐	☐	Glaucoma
☐	☐	Kidney stones / disease
☐	☐	Bloody stools
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Ulcers
☐	☐	Menstrual cramping / pelvic pain
☐	☐	Loss of memory
☐	☐	Shortness of breath
☐	☐	Diarrhea
☐	☐	Sudden weight loss
☐	☐	Muscle cramping
☐	☐	Loss of hearing
☐	☐	Headache
☐	☐	Epilepsy / seizures
☐	☐	Tuberculosis
☐	☐	Knee / hip replacement
☐	☐	Sprained ankle — right
☐	☐	Osteoporosis / low bone density
☐	☐	Pregnant or possible pregnancy

Notes / specify (broken bones, STI, etc.) _____

GENERAL ACTIVITIES

Check all that apply to your usual routine.

- ☐ Read in bed
- ☐ Needlework / crafts
- ☐ Lift weights / machines
- ☐ Jog / run
- ☐ Gym / cardio equipment
- ☐ Fall asleep in recliner / couch
- ☐ Two or more pillows
- ☐ Video games
- ☐ Computer / desk work
- ☐ Watch television
- ☐ Sleep on stomach
- ☐ Sewing
- ☐ Exercise regularly
- ☐ Swim

Exercise × / week _____ Jog × / week _____ Screen / game hrs per day _____

Anything else you would like the doctor to know?

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that the information on this form is true and complete to the best of my knowledge. I understand that incorrect information can be dangerous to my health and may affect insurance benefits. I authorize Northgate Chiropractic and its providers to release information reasonably necessary for treatment, payment, and health care operations to third-party payers, attorneys I designate, and other health practitioners involved in my care related to this accident. I assign and authorize payment of insurance benefits (including Washington PIP / med-pay and any applicable health or liability coverage) directly to Northgate Chiropractic for services rendered. I understand my insurer may pay less than the full charges and that I remain responsible for balances not paid by insurance, except as limited by law or written agreement. Health information I provide may be consumer health data under Washington's My Health My Data Act (MHMDA) and is handled per the clinic's privacy practices (northgatechiro.com/privacy). This form does not replace any separate PIP application my auto insurer may require.

☐ I have read and agree to the authorization above

Patient / guardian printed name _____ Date _____

Signature (type full legal name if completing electronically)

_____

Parent or guardian signature required if the patient is a minor.
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OFFICE USE ONLY

Complete after review with the patient. Keep with the chart.

Date of exam | Provider | Account / case #

PIP / claim verified | Police report received

Doctor's comments / examination notes

Provider initials | Date | Next visit