



Milwaukie Spine and Sport, LLC
 2100 SE Lake Rd. Suite 1
 Milwaukie, OR 97222
 503-344-6711 P
 milwaukiechiropractor.com

Motor Vehicle Collision Addendum

Tell us about your accident

Please notify us if you were **on the job** at the time of the accident, you will need additional paperwork.

Date of Accident: _____ Time of Accident: _____ State Accident Occurred in: _____

Who is your insurance Carrier? _____ What is your claim #: _____

Who is your attorney?: _____ Attorneys Phone #: _____

Your vehicle(circle one): Was struck by another vehicle Struck another vehicle

Briefly describe the accident details: _____

On a scale of 1-10(10 being the worst) how bad is your pain currently? _____

What was your position in the car at the time of the accident?

- Driver
- Front Passenger
- Drivers Side Rear
- Passenger Side Rear

After the accident were you in the same position in the car?

- Yes
- If no, what position? _____

Did airbags deploy?:

- Yes
- No

The accident was:

- Head on
- Broadside
- Read end
- Single vehicle collision

The other vehicle in the accident was a:

- Car
- Van
- Truck
- Commercial Vehicle(semi/box truck)

The damage to your vehicle was on(check all that apply):

<input type="checkbox"/> Front end <input type="checkbox"/> Back end <input type="checkbox"/> Roof	<input type="checkbox"/> Drivers side <input type="checkbox"/> Passenger side <input type="checkbox"/> Windshield/Windows
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As a result of the accident, were you:

- Rendered unconscious
- Dazed/foggy/confused
- Shaken but functional

For Office Use Only

Patient Name: _____ DOB: _____ Provider: _____ Date: _____



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Tell us about your accident continued...

Tell us about your body's position at the time of impact:

<input type="checkbox"/> Head(looking forward)	<input type="checkbox"/> Body(facing forward)
<input type="checkbox"/> Head(looking right)	<input type="checkbox"/> Body(twisted right)
<input type="checkbox"/> Head (looking left)	<input type="checkbox"/> Body(twisted left)
<input type="checkbox"/> Head(looking up)	<input type="checkbox"/> Body(bending forward)
<input type="checkbox"/> Head(looking down)	<input type="checkbox"/> Body(bending backwards)

At the time of the accident was your car:

- Slowing down
- Speeding up
- Maintain Speed
- Stopped

Were you able to exit the vehicle under your own power?

- Yes
- No, Why not? _____

Were you able to move all parts of your body after the accident?

- Yes
- No, what couldn't you move? _____

Symptoms after the Accident

(Please check all that apply)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression	<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Mid Back Pain/Stiff	<input type="checkbox"/> Low Back Pain/Stiff	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Pain Behind Eyes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Flushing	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Pins and Needles	<input type="checkbox"/> Short of Breath
<input type="checkbox"/> Heavy head	<input type="checkbox"/> Numb Extremities	<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Bowl changes	<input type="checkbox"/> Tension	<input type="checkbox"/> Fever	<input type="checkbox"/> Fainting
<input type="checkbox"/> Seizures	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Vision changes	<input type="checkbox"/> Confusion

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Doctor's Lien and Assignment of Right to Recovery

- I do hereby authorize Milwaukie Spine and Sport, LLC to furnish my attorney and/or insurance carrier, with information regarding the accident in which I was involved.
- I understand that I am directly responsible to Milwaukie Spine and Sport, LLC for any and all bills submitted for services. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. In consideration of not having to immediately pay debt for care, I hereby assign and convey to Milwaukie Spine and Sport, LLC a legal and equitable interest in any and all causes of action of rights of recovery.
- I hereby authorize my attorney, and insurance company to pay directly to Milwaukie Spine and Sport, LLC, that which is owing for professional services as a result of this accident and by reason of any other bills that are due to Milwaukie Spine and Sport, LLC including attorney fees. These are to be withheld from any settlement or judgment I hereby further give a lien on my case to Milwaukie Spine and Sport, LLC against any and all proceeds of my settlement, judgment or verdict which may be paid to you as result of the injuries for which I have been treated.
- I further instruct a separate check to be issued to Milwaukie Spine and Sport, LLC for services rendered.

I have read this document, I understand it, and I voluntarily agree to be bound by it. I am directing my attorney to protect the interests of Milwaukie Spine and Sport, LLC as provided herein.

Signature of Patient/Gurantor: _____

Name of Patient/Guarantor: _____ Date: _____

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