JustBreathe Wellness Center

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**Personal Injury /Auto Accident or Slip & Fall Case**

♦ Do you have MED-PAY benefits? YES NO

♦ Are there benefits left? YES NO

♦ Do you have a deductible? YES NO

♦ What are the policy limits $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦ Do you have U/M (Uninsured Motorist Protection)? YES NO

♦ Were you cited in the accident? YES NO Don't know

♦ Were you the: Driver Front Passenger Rear Passenger Pedestrian Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦ Did you have your seat belt on? YES NO

♦ Were you struck from: Behind: Front: R. Side: L. Side:

If other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦ Did you feel pain immediately? YES / NO Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If NO, when did you first start feeling pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦ Since the injury are your symptoms: Getting Worse Improving Staying the same Changing

 (If changing, explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦ Have you received massage therapy for this medical condition? YES / NO

♦ Have you received massage therapy for any medical condition in the past? YES / NO , If YES, did it help? YES / NO

♦ Have you had any recent or past accident? YES / NO If YES, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you sustained injuries? If YES, Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you live in a state that is not a No-Fault state or DO NOT have MED-PAY on your policy, you must**

**supply the following information.**

**INFORMATION ON DRIVER OF VEHICLE AT FAULT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Auto Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you obtained an attorney for this case? YES / NO

 If YES, Please fill out our **Attorney Letter of Protection** and provide your attorney’s name, phone and fax numbers.

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