Automobile Accident Questionnaire

Please answer all questions Completely

Dear patient: this information is considered confidential. If we need this information to better understand the events surrounding your unfortunate trauma, and your answers will help us determine if chiropractic care can help you. In order for us to understand your condition of, please be as need an accurate as possible what we need is for. Thank you.

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____
AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY # _____
E-MAIL: _____
EMPLOYER: _____ ĺ FULL TIME ĺ PART TIME
ADDRESS: _____ WORK PHONE: _____
OCCUPATION: _____ DRIVERS LIC. #: _____
SPOUSE/EMERGENCY CONTACT: _____
ADDRESS: _____ HOME PHONE: _____
RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

Accident Information: Date of Accident: _____ City of Accident: _____
Police Report: □ Yes □ No (If yes, please provide us with a copy of the police report)

Accident Description:

1. Your Vehicle

□ Car □StationWagon
□ Van □ Pickup Truck
□ Bus □ Large Truck

2. Your Position in Vehicle

□ Driver □ Front Passenger
□ Left Rear
□ Right Rear

3. What was your vehicle doing?

□ **Stopped** □ Intersection □ in traffic □at Light
□ Turning □ right □ Left □ Parking
□ Proceeding along □ Slowing down □ Accelerating

4. Time/Speed/Damage

Time:
Your Vehicle's Speed MPH
Other Vehicle's Speed MPH
Damage to your vehicle
□ Mild □ Moderate
□ Totaled

5. Details of Accident

Visibility at time of accident
□ Poor □ Fair □ Good

Who hit who/what?
□ You hit other vehicle
□ Other vehicle hit you
You hit…(object):

6. Road Conditions

Road conditions at time of accident
□ Icy □ Wet □ Sandy □ Dark □ Clean and dry

Point of impact
□ Head-on □ Left Front □ Right Front
□ Rear-end □ left Rear □ Right Rear
□ Right Side (Passenger) □ Left Side (Driver)

7, Body Position

Did you see the accident coming? □ Yes □ No
Were you braced for the impact? □ Yes □ No
Did you have a seat belt on? □ Yes □ No
Did you have a shoulder harness on? □ Yes □ No
Did your airbag deploy □ Yes □ No

8. Does your vehicle have headrest? □ Yes □ No

What was the position of your headrest?
□ Even with top of head □ Even with bottom of head
□ Middle of neck
What was the direction of your head?
□ Facing straight forward □ Turned to the right
□ Turned to the Left

9. During and after the Accident:

Did your body strike the inside of your vehicle □ Yes □ No
If yes, describe: _____
Did you lose consciousness? □ Yes □ No
If yes, how long? _____
Vehicle's estimated damage: _____

Emergency Room:
Where did you go after the accident?
□ Home □ Work □ Hospital ER □ Private Doctor
How did you get there?
□ Drove Self □ Somebody else □ Ambulance □ Police

10. After the accident:

□ Headache □ Dizziness □ Mid back pain
□ Neck Pain □ Nausea □ Low back pain
□ Neck Stiff □Confusion □ Nervousness
□ Fainting □ Fatigue □ Loss of taste
□ Ring in ears □ Tension □ Constipation
□ Loss of smell □ Irritability □ Cold hands
□ Eye Pain □ Anxious □ Chest pain
□ Numbness: □Arms □ Hands □ Legs □ Feet
□ Problems Sleeping □ Shortness of Breath
Others:

11. Treatment History:

Hospital: Date of Visit: _____
xrays: □ Neck □ Head □ Mid Back □ Low Back □ Chest
Lab Work
Medications
Treatments □ Medication □ Brace □ Injection
Other:

Doctor: _____ Date of Visit: _____
xrays: □ Neck □ Head □ Mid Back □ Low Back □ Chest
Lab Work
Medications
Treatments □ Chiropractic □ MD □ PT □ Pain Man
Explain:

Continued on Back ⇨

Additional Accident Information: _____

_____

_____

Current Locations of Pain (Mark all that apply):

□ Head □ Neck □ Arms □ Upper Back □ Mid Back □ Chest □ Ribs □ Low Back □ Buttock □ Legs □ Feet

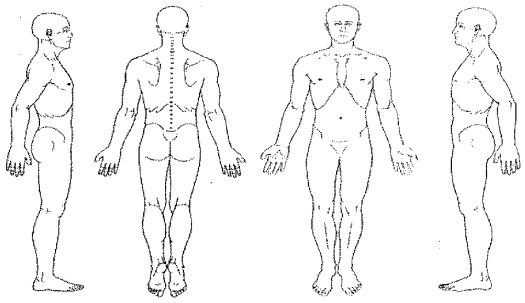
Other: _____

Type of Current Symptoms:

□ Dull pain □ Sharp pain □ Burning pain □ Throbbing pain □ Shooting pain □ Cramping □ Spasm □ Stiffness

□ Numbness Arms/hands □ Numbness Legs/feet □ Dizziness □ Spinning sensation □ Lightheaded □ Nausea

Other: _____



Mark Your Pain on the Above Diagram

On the scale below, rate your pain intensity by circling the appropriate number: 0= no pain, 10 = unbearable pain.

1	2	3	4	5	6	7	8	9	10

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

To what degree do your symptoms interfere with your daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms		Mild Forgotten with activity		Moderate interferes with activity		Limiting Prevents Full activity		Intense preoccupied with pain		Severe no activity possible

My symptoms interfere with my: □ Sleep □ Work □ Personal Care □ Social life □ Recreation □ None of these

Currently your pain is aggravated by:

□ Coughing □ Neck Movements □ Bending □ Walking

□ Sneezing □ Reaching □ Lifting □ other:_____

□ Straining at Stool □ Sitting □ Standing □ None of these

Have you ever had complaints in the involved areas before? □ Yes □ No

Have you ever had prior treatment for any same or similar condition? □ Yes □ No

Before the accident were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work or daily activities restricted as a result of this accident? □ Yes □ No

Since the injury are your symptoms □ Improving? □ Getting worse? □ Same?

I understand and agree that health and accident policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assisting in making collection from the insurance company and that any amount authorized to be paid to directly to this Chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____