Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept our case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Date: _____________ Name: ____ Sex: M F Marital Status: _____________
DOB: ______ Cell Phone: ______________ Home Phone: ______________ Email:____

Address: ____City ________________State_____Zip______

Occupation: _____________________________ Who referred you to our office? __________________ (indicate if minor, student, housewife, unemployed, retired) Social Sec. # __________________Work Phone: _____________Company/Location_________________

Spouse's Name: ____________________________________Phone #: ____________________________

Please explain in detail how your accident happened ____
____
____
____

Insurance Co. ____________________________ Policy # _____________________ Claim # __________

What WAS the date and time of the present injury (s)? ____

Driver of other vehicle in which you were injured (if applicable) Name____________________________ Insurance Co.__________________ Policy #________________

Who else was in the vehicle with you? ________________________ Are they getting treated? Y / N Has the other person in vehicle gotten care for accident? Y / N Name of your insurance adjustor ____________________________Have you retained an attorney? Y/N

If so the attorneys' name and address ____

You were headed ☐North ☐East ☐South ☐West on ___________________________ (street or highway)
Other vehicle was headed ☐North ☐East ☐South ☐West on ______________________(street or highway)
Were police notified? Yes / No Did you brace yourself for the crash? ☐Yes ☐No
Were you knocked unconcious? ☐Yes ☐No If so how long? __________________ Did the airbags deploy? ☐Yes ☐No
Did any part of your body hit inside the car? Y / N What part of your body? _______________________
You were struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side Did you feel ☐ Dizzy ☐ Shocked ☐ Scared
You were ☐Driver ☐Passenger ☐Front Seat ☐Back Seat ☐Using Seat Belt ☐Other Protective Device
Where did you feel pain immediately after the accident? _____________________________________
Where were you taken after the accident? ____
How were you transported? _______________________ What treatment was given? ____
____

Was any other doctor consulted after your accident? ☐Yes ☐ No
If so, give doctors name __________________________________ ☐D.C., ☐ M.D., ☐ D.O, ☐ D.D.S.
What was the diagnosis? ____
What treatment was given?
____
How often did you see the doctor? ___________ How long did you see the doctor? ________________
Did you have an MRI, CT SCAN, or Xrays done? Y / N If so which did you receive? _______________
Have you ever had complaints in the involved area before accident? ☐Yes ☐NO
If so, what were the complaints? ____
Before the inury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your work activities restricted as a result of this accident? ☐Yes ☐No
Since this injury are your symptoms ☐ improving? ☐ getting worse? ☐ the same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes:**N-Now P-Previous**

Musculo-skeletal System

___Low back problems
___Pain between shoulders
___Neck problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Weak muscles
___Walking problems
___Ruptures
___Broken bones

Genito-urinary System

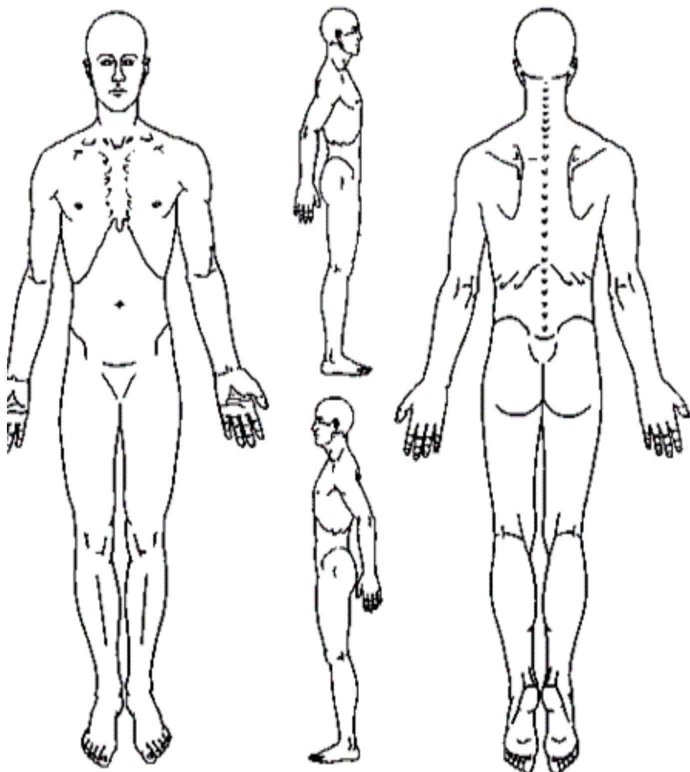
___Bladder trouble.
___Excessive urination
___Scanty urination
___Painful urination
___Discolored urine

FEMALE

___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast

Are you pregnant?

___Yes ___No



Gastro-Intestinal System

___Poor appetite
___Excessive hunger
___Difficult chewing
___Difficult swallowing
___Excessive thirst
___Vomiting food
___Nausea
___Vomiting blood
___Abdominal pain
___Constipation
___Diarrhea
___Black stool
___Bloody stool
___Hemorrhoids
___Liver trouble
___Gall bladder problems
___Weight trouble

Nervous System

___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Headaches
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression

Cardio-Vascular-Respiratory System

___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid heartbeat
___Heart problems
___Blood pressure problems
___Varicose veins.
___Lung problems

Eye, Ear, Nose, and Throat

___Eye strain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Hearing loss
___Ear discharge
___Nose pain
___Nose bleeding
___Nose discharge
___Difficult breathing thru nose
___Hoarseness
___Sore gums
___Dental problems
___Sore mouth
___Sore throat
___Difficult speech

Patient Signature: Date: