AUTOMOBILE ACCIDENT QUESTIONAIRE

Dear patient: Date: ____________________

Please complete this entire form. The information is necessary to help us assess your need for care, and to accurately document your treatment file. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

GENERAL INFORMATION

Name ________________________________ Sex ___ DOB ___/___/____Home Ph. ____________________

Address ______________________________________City ______________________ State ____ Zip ________

Insurance Company ____________________________ Ph. (____) __________________ Your Ins? ___Y ___N

Claim #______________________________Name of Adjuster_______________________________________

NATURE OF ACCIDENT

1. What was the time and date of this present injury? Date: _____M _____D 20______ time ___:____ am / pm

2. Please explain in your own words how your accident happened. ____

____

____

3. Were you : ____ Driver _____ Passenger _____Front seat ______ Back seat

4. What direction was your vehicle headed? _______North _______South _______East _______West

5. What direction was the other vehicle headed? ______North _______South _______East ______West

6. Were you struck from: ______behind ______front ______L side ______R side

7. How many cars were involved in the accident? ____

8. Were you wearing a seat belt? ___Y ____N Other protective devices? _____________________________

9. Did you come in contact with any objects in the car? ___N ____Y If yes, what objects? __________________

____

10. What parts of your body came in contact with the above? ____

____

11. Were you unconscious as a result of the injury? __N __Y
If yes, how long? ____________________________

12. Were you bleeding as a result of the injury? ___ N ___Y

13. Where did you feel pain or unusual feeling immediately after the accident? (Please show the areas on the diagram)

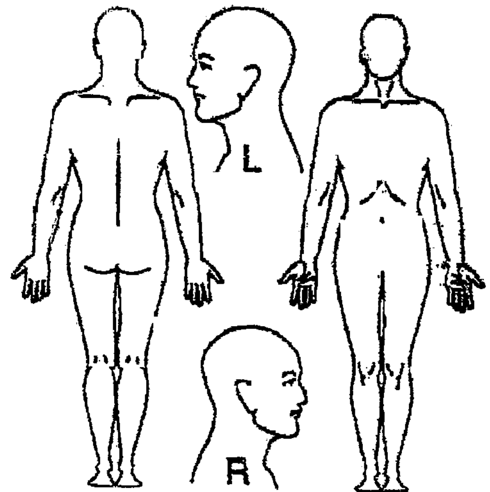
14. Were the police notified? ___N ___Y

15. Were you taken anywhere after the accident other than home? ____________________________________

16. What treatment did you receive? ________________

____

____



17. Was any other doctor consulted after your accident? ____N ____Y If yes, what was the doctor's name?

____ ____DC ____MD ____DO ____DDS

18. Describe the doctor's diagnosis. ____

____

19. What treatment did you receive? ____

20. Are you still under a doctor's care? ___N ___Y If yes, please explain. ____________________

____

PAST HISTORY

1. Have you ever injured this area before? ___ N ___Y If yes, when? ______________________

2. Have you been involved in any previous accidents of any kind (personal injury, auto accident or Workers' Compensation)

   ___N ___Y If yes, please explain dates and details ____________________________

   ____

3. Have you ever been treated by a chiropractor before? ___N ___Y If yes, who and when?__________

   ____

4. Have you enjoyed good health prior to this accident? ___N ___Y If no, please explain (illness, etc.)__________

   ____

PRESENT INFORMATION/DISABILITY

1. Have you returned to work? ___N ___Y If yes, date you returned to work. ________________

2. Job description ____

3. Are your work activities restricted as a result of this accident? ___N ___Y If yes, please explain __________

   ____

4. Do you notice any activity restrictions as a result of this injury? ___N ___Y If yes, please explain __________

   ____

5. Since this injury, have your symptoms: ____ improved ____ got worse ______ the same?

LEGAL REPRESENTATION

1. Have you retained an attorney? ___N ___Y If yes, name, address and phone number ______________

   ____

I certify that I have read and understand the above information and have answered the above questions to the best of my knowledge. I understand that omitting or providing incorrect information can be dangerous to my health and could jeopardize my insurance claim.

________________________________ ____________________

Patient's Signature (or Parent/Legal Guardian) **Date**

____

Patient Name (Print)