Automobile Accident Questionnaire

Date: _____ / _____ / _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Home Phone: (_____)_____ Business/Cell Phone: (_____)_____ Email:_____ _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: _____ Marital Status: S M W D

Number of Children: ____ Social Security Number: _____ Have you retained an attorney: ☐Yes ☐No

If Yes, list Name & Phone – Name: _____ Phone: (_____)_____

Who referred you to our office and the professional services we offer? _____

Have you received any type of chiropractic care in the past? ☐Yes ☐No Were you pleased with their care? ☐Yes ☐No

If yes, why did you discontinue your chiropractic care? _____

THE ACCIDENT

1) Date Of Accident: _____ / _____ / _____ 2) Time Of Accident: _____:_____ AM PM

3) Please explain, in detail, how the accident happened:

_____

_____

_____

_____

_____

_____

4) You were heading: ☐North ☐South ☐East ☐West on _____(street/highway)

5) Were you struck from: ☐Behind ☐Front ☐Right Side ☐Left Side

6) Were you the: ☐Driver ☐Passenger ☐Front Seat ☐Back Seat ☐Using Seat Belts Number Of Passengers In Auto: ___

7) Did your seat have a headrest: ☐Yes ☐No 8) Were you: ☐Surprised by the impact ☐Braced for the impact

9) At the time of the impact were you looking: ☐Straight ahead ☐To the left ☐Up ☐To the right ☐Down

10) Did any part of your body strike anything in the vehicle: ☐Yes ☐No If yes,explain: _____

11) Were the police notified: ☐Yes ☐No 12) Was a police report filed: ☐Yes ☐No

13)Was a traffic violation issued: ☐Yes ☐No 14)If yes, to whom: _____

YOUR HEALTH

1) Were you knocked unconscious: ☐Yes ☐No If yes, for how long: _____

2) Did your head strike the windshield/object: ☐Yes ☐No

3) When did you feel pain: ☐Immediately ☐Later that day ☐Next day ☐Other _____

4) Where did you feel pain after the accident: _____

5) Were you taken anywhere after the accident: ☐Yes ☐No 6) Was treatment given: ☐Yes ☐No

What type of treatment: _____

7) Have you seen any other doctor for injuries from this accident: ☐Yes ☐No

If yes, Name & Degree: _____ M.D./D.C./D.O./D.D.S.

Their diagnosis: _____ Are you still treating with this doctor: ☐Yes ☐No

Were any of the following taken: ☐X-Rays ☐MRI ☐CT Scan ☐Other:_____

8) Have you had complaints in the involved area before: ☐Yes ☐No If yes, list: _____

9) Before the accident, were you capable of working on an equal basis with others your age: ☐Yes ☐No

10) Are your activities restricted as a result of the accident: ☐Yes ☐No

11) Since the injury, are your symptoms: ☐Improving ☐Getting Worse ☐The Same

INSURANCE

1) Name of owner and/or driver of vehicle in which you were injured (self or others): _____

_____

2) Insurance Company: _____ 3) Phone Number: (_____)_____

4) Policy Number: _____ 5) Claim Number: _____

6) Adjuster's name: _____ 7) Phone Number: (_____)_____

8) Driver of *other* vehicle (if any): _____

9) Insurance Company: _____ 10) Phone Number: (_____)_____

11) Policy Number: _____ 12) Claim Number: _____

13) Adjuster's name: _____ 14) Phone Number: (_____)_____

Name: _____ Date: _____ / _____ / _____

CHECK EACH CONDITION THAT YOU ARE EXPERIENCING OR HAVE IN THE PAST

MUSCULO-SKELETAL SYSTEM

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Hip Pain
- ☐ Broken Bones
- ☐ Shoulder Pain

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Exercise
- ☐ Drug Abuse
- ☐ _____

GENITO-URINARY SYSTEM

- ☐ Bladder Trouble
- ☐ Excessive Urination
- ☐ Scanty Urination
- ☐ Painful Urination
- ☐ Discolored Urine *Female*
- ☐ Vaginal Discharge
- ☐ Vaginal Bleeding
- ☐ Vaginal Pain
- ☐ Breast Pain
- ☐ Lump(s) on the Breast

ARE YOU PREGNANT?
Check appropriate box & initial in blank line.

- ☐ Yes _____
- ☐ No _____

First Day of Last Menstrual Period ____ / ____ / ____

GASTRO-INTESTINAL SYSTEM

- ☐ Poor Appetite
- ☐ Excessive Hunger
- ☐ Difficult Chewing
- ☐ Difficult Swallowing
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Stool
- ☐ Bloody Stool
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of Feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle Jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

CARDIO-VASCULAR/ RESPIRATORY

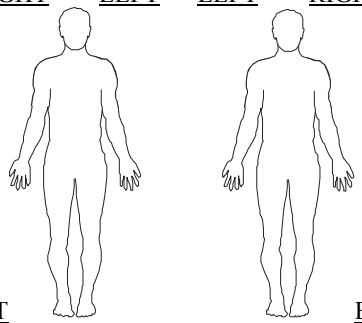
- ☐ Chest Pain
- ☐ Pain Over Heart
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Phlegm
- ☐ Coughing Blood
- ☐ Rapid Heartbeat
- ☐ Blood Pressure Problem
- ☐ Heart Problem
- ☐ Lung Problem
- ☐ Varicose Veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye Strain
- ☐ Eye Inflammation
- ☐ Vision Problem
- ☐ Ear Pain
- ☐ Ear Noises
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Nose Pain
- ☐ Nose Bleeding
- ☐ Nose Discharge
- ☐ Difficulty Breathing Through Nose
- ☐ Sore Gums
- ☐ Dental Problems
- ☐ Sore Mouth
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Speech Problem
- ☐ Sinus Problems
- ☐ Allergies
- ☐ Jaw Pain

Mark Your Areas Of Complaint With An "X"

RIGHT LEFT LEFT RIGHT



FRONT _____ BACK

Patient Signature: X_____ Date: ____ / ____ / ____

Describe Symptom (*Circle*): Using a Scale of 1-10: Patient's Rep Signature: X_____ Date: ____ / ____ / ____

Pain	Tender	1 = Best / 10 = Worst
Numb	Tingling	Indicate *your* overall
Spasm	Other_____	level of discomfort:___

Relationship/Authority Of Patients Representative: _____

Doctor Signature: X_____ Date: ____ / ____ / ____

For Doctor Use Only

353.0	___Brachial Plexus Lesions	724.8	___Facet Syndrome	756.12	___Spondylolisthesis	_____	_____
715.5	___Osteoarthritis-Hip	728.8	___Cervical Myofascitis	843.9	___Hip or Thigh Sp/St	_____	_____
720.2	___Sacroilitis	729.1	___Myofascitis, Unspec.	846.1	___Sacroiliac Lig'mt Sp/St	_____	_____
723.1	___Cervicalgia	737.3	___Neuralgia Unspec.	846.8	___Sacroiliac Sp/St	_____	_____
723.4	___Brachial Radiculitis	737.3	___Scoliosis	847.0	___Cervical Sp/St	_____	_____
724.1	___Thoracalgia	739.0	___Occipital/Cervical Dysf	847.1	___Thoracic Sp/St	_____	_____
724.2	___Lumbalgia	739.1	___Cervical Seg Dysf	847.2	___Lumbar Sp/St	_____	_____
724.3	___Sciatica	739.2	___Thoracic Seg Dysf	847.3	___Sacral Sp/St	_____	_____
724.4	___Lumbar Radiculitis	739.3	___Lumbar Seg Dysf	847.4	___Coccyx Sp/St	_____	_____
724.4	___Thoracic Radiculitis	739.4	___Sacroiliac Seg Dysf	Other	___ _____	_____	_____
724.79	___Coccydynia	739.5	___Pelvis/Hip Seg Dysf				