# AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: This information is 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 your case. In order for us to understand your condition properly, please be as neat, complete, and accurate as possible in completing this form. Thank you.

Name _____ Sex____ Marital Status____ Birth Date___/___/___ Home phone_____

Address_____ City_____ State____ Zip_____ Work phone_____

Occupation_____ Who referred you to our office? _____
(Indicate:child/student/housewife/unemployed/retired)

ACCIDENT DESCRIPTION: Date of accident___/___/___

Type of cars-Yours: _____ Theirs: _____

Were you the Driver? Yes No …or a Passenger? Yes No Where were you sitting? Front back left right middle

If you were not the driver, who was driving? _____

Were you wearing a seat belt? Yes No Airbag Deployed? Yes No

Did the car have a headrest? Yes No How far from your head?_____

Describe the accident:_____

_____

Was there a ticket issued? Yes No If yes, to whom?_____

Estimated speed of your vehicle: _____ Speed of their vehicle: _____

Impact occurred where on your car:_____ Impact on their auto:_____

How many people were in your car _____ Number in theirs _____

Was an ambulance needed for you? Yes No For them? Yes No

Was a tow truck used for your car? Yes No For theirs? Yes No

What hospital did you go to? _____

Briefly, what treatment did you receive?_____

_____

What did the doctors tell you?_____

What additional care have you received? (Include medicines, therapy etc.) _____

_____

What other tests have been ordered? MRI C.T.Scan Blood Tests Other_____

PAST MEDICAL HISTORY:

What doctors have you consulted in the past?_____

A. Internal Disorders:
   Symptoms_____
   Diagnosis & Treatment_____
   Treating Doctor_____
B. Muscle and Skeletal Disorders:
   Symptoms_____
   Diagnosis & Treatment_____
   Treating Doctor_____
C. Eyes, Ears, Nose and Throat:
   Symptoms_____
   Diagnosis & Treatment_____
   Treating Doctor_____
D. List any other conditions that you have received treatment for in the past:_____
   _____

GENERAL HEALTH QUESTIONNAIRE: (circle area of involvement)

ARMS/HANDS Do they hurt? Yes No Right Left Both
Or Describe the type of pain_____
LEGS/FEET Do temperature changes affect the pain? Yes No
Is there numbness? Yes No All the time? Yes No A.M. P.M.

MID-BACK Do you have pain? Yes No
Or Describe the type of pain_____
NECK What makes it worse?_____
What makes it better?_____
Does standing, sitting, walking, lifting or any other activity bother this area? Yes No
If so, describe_____

LOW BACK Do you have pain? Yes No
Describe the type of pain_____
Is pain constant-comes & goes-does it spread-buttocks pain, leg pain, etc._____
What makes it worse-sitting, standing, walking, sleeping, coughing, sneezing, bowel movements, bladder, other_____

MENTAL FUNCTION Do you have difficulty remembering old phone numbers, what you are doing, where you Parked the car. Do you experience mental confusion, depression, nervousness? Do you have difficulty doing any task? Explain_____

JAW Does it hurt? Yes No Does it pop or click? Yes No
Does it feel tight? Yes No Are your teeth sore or painful? Yes No
Do you have gum trouble? Yes No
Do you have difficulty in taking bites of apples or other foods? Yes No
Explain_____

PLEASE COMPLETE THE FOLLOWING IF THIS IS AN INSURANCE CLAIM:

Insurance Company_____ Policy#_____
Claim#_____
Attorney obtained? Yes No If yes: Attorney's Name_____

OTHER-Please list any other pain or discomfort that you are now experiencing:

_____ _____
Date Patient's signature

PLEASE DO NOT WRITE BELOW THIS LINE_____
_____
_____
_____

Patient accepted? Yes No Doctor's signature_____