

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 Do you have difficulty remembering old phone numbers, what you are doing, where you
FUNCTION 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 _____