VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last	First	Middle	HOME PHONE	DATE

ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY #	AGE	BIRTH DATE	SEX	MARITAL STATUS	NO. OF CHILDREN

EMPLOYER	ADDRESS	BUSINESS PHONE

OCCUPATION	WHO REFERRED YOU TO OUR OFFICE?

INSURANCE INFORMATION

YOUR INSURANCE COMPANY	POLICY NO.	CLAIM NO.

NAME OF OTHER VEHICLE'S DRIVER	OTHER VEHICLE'S INSURANCE COMPANY	POLICY NO.

NAME OF YOUR VEHICLE'S DRIVER	YOUR VEHICLE'S INSURANCE COMPANY	POLICY NO.

NAME OF YOUR INSURANCE ADJUSTER PHONE

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT occurred:

DATE AND TIME OF ACCIDENT: ☐ A.M. ☐ P.M.

WERE POLICE NOTIFIED? ☐ Yes ☐ No

YOUR VEHICLE WAS HEADING:

☐ North ☐ South ☐ East ☐ West ON: ☐ Street ☐ Highway

OTHER VEHICLE WAS HEADING:

☐ North ☐ South ☐ East ☐ West ON: ☐ Street ☐ Highway

YOUR VEHICLE WAS STRUCK FROM THE:

☐ Front ☐ Back ☐ Driver's Side ☐ Passenger's Side

YOU WERE: ☐ Driver ☐ Front Seat ☐ Passenger ☐ Back Seat

WERE YOU USING A SEAT BELT? ☐ Yes ☐ No

WERE YOU UNCONSCIOUS? IF YES, HOW LONG?

☐ No ☐ Yes ►

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?

EXACT AREA(S) OF PAIN IMMEDIATELY AFTER ACCIDENT:

WHAT TREATMENT WAS GIVEN?

WHAT DIAGNOSIS WAS GIVEN?

DOCTOR'S NAME:

HOW OFTEN DID YOU SEE THIS DOCTOR?

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS & PHONE:

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE

☐ No ☐ Yes ►

HAVE YOU RETAINED AN ATTORNEY? IF YES, GIVE NAME, ADDRESS & PHONE

☐ No ☐ Yes ►

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?

☐ No ☐ Yes ►

BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?

☐ Yes ☐ No

SINCE THIS INJURY, ARE YOUR SYMPTOMS:

☐ Improving ☐ The Same ☐ Getting Worse

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AUTOMOBILE ACCIDENT HISTORY FORM

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of accident: _____ am/pm

City of Accident _____ Street of accident: _____

Road conditions at the time of the accident: WET DRY ICY OTHER _____

Did the police come to the accident scene? YES NO Is there a report? YES NO

Did you go to a hospital? YES NO
If yes, what is the name and city of the hospital? _____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____
What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO How long: _____

Did you experience a flash of light or explosion in your head? YES NO

Did you become CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED
BLURRED VISION RING/BUZZ IN EARS

If you still have any of these symptoms, which ones? _____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	IRRITABLE
DIFFICULTY CONCENTRATING	DIFFICULTY WITH MEMORY
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seatback from the top of your head
(approximately): _____ inches above or below

Were you wearing a seatbelt? YES NO
If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____

List the year, make and model of the vehicle you were in:
year_____ make _____ model _____

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, then estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it:
slowing down? YES NO
gaining speed? YES NO
traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?
head hit _____ chest hit _____
right/left shoulder hit _____ right/left arm hit _____
right/left hip hit_____ right/left leg hit_____
right/left knee hit _____ other _____

Did you receive any injury or bruise from the seat belt? YES NO
If YES, then describe: _____

What is the estimated cost damage to the vehicle you were in? $ _____

Which of the following car parts broke during the accident? (please circle)
windshield front seat back
right/left side window other _____
steering wheel other _____

Was the trunk of your body pointed straight forward at the time of the collision? YES NO
If no, how was it turned? _____

Was your head pointed straight forward? YES NO If no, what direction was it turned and by how much? _____

What is the year, make and model of the **other** vehicle?
year _____ make _____ model _____

Was the other vehicle moving at the time of the collision? YES NO
If yes, what was its approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it (please circle):
slowing down gaining speed travelling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____