

Automobile Accident Questionnaire

Please Answer All Questions Completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answer 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 and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Cell Phone _____ Work Phone _____ Preferred Contact No. Hm. _____ Wk. _____ Cell _____

Email Address _____ Do you give us permission to contact you by e-mail/and or send

you an email newsletter? Yes _____ No _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

(Indicate if child, student, housewife, unemployed or retired)

Social Security No. _____ Business Phone Number _____ Company Name _____

Address _____ State _____ Zip _____

Please explain in detail how your accident happened _____

Do you have Personal Injury Protection (PIP)? Yes _____ No _____ If so, what is the name of your Car Insurance? _____

Claim No. _____ Adjuster's Name _____

Adjuster's Telephone No. _____ Adjuster's Fax No. _____

Have you retained an attorney? Yes _____ No _____

If so, name and address _____

Did your accident take you completely by surprise? Yes _____ No _____

Immediately prior to impact, were you looking straight ahead? _____ to the right? _____ or to the left? _____ Was head straight up? _____ or down? _____

Did any part of you hit anything inside your car? Yes _____ No _____ If so, what part(s) hit? _____

Did your car strike or get hit by any other car? Yes _____ No _____ If so, what was struck? _____

Give time and date present injury occurred: Date _____ Time _____ am _____ pm _____

Were you heading North _____ East _____ South _____ West on _____ (street or highway)

Other vehicle was headed North _____ East _____ South _____ West on _____ (street or highway)

Were police notified? Yes _____ No _____

Were you knocked unconscious? Yes _____ No _____ If so, for how long? _____

Were you struck from Behind _____ Front _____ Left Side _____ Right Side _____

Were you Driver _____ Passenger _____ Front Seat _____ Back Seat _____ Using seat belts _____ Other protective devices _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Did you consult any other doctor after your accident? Yes _____ No _____ D.C., _____ M.D., _____ D.O., _____ D.D.S.

If so, give doctor's name _____

Doctor's diagnosis _____

What treatments did you receive? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes _____ No _____ If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others of your age? Yes _____ No _____

Are your work activities restricted as a result of this accident? Yes _____ No _____

Since this injury are your symptoms Improving? _____ Getting worse? _____ The same? _____