Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient:

We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care 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 ____ D.O.B.____/____/____

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

Phone_________________________ Cell____________________________

Email____

Address______________________________________

City_________________________________State______Zip__________

SSN#_____________________ Occupation___________________________

Who referred you to our office?__________________

Spouce/ Significant other

Name ____ D.O.B.____/____/____

Phone_________________________ Cell____________________________

Email____

Address______________________________________

City_________________________________State______Zip__________

SSN#_____________________ Occupation___________________________

Please explain in detail how your accident happened

Date of accident___________________ Time of accident_______________AM/PM

Driver of other vehicle (if any)

Name____

Insurance Co____

Policy#____

Claim#____

Driver of vehicle in which you were injured (if applicable)

Name____

Insurance Co____

Policy#____

Claim#____

Name of your insurance adjustor
____

Have you retained an attorney? [ ] Yes [ ] No

If yes, their name and address and phone number
____

You were heading [ ] North [ ]East [ ] South [ ] West
on____ Street-Ave-Rd-HWY

Other vehicle was headed [ ] North [ ]East [ ] South [ ] West
on____ Street-Ave-Rd-HWY

Were police notified? [ ] Yes [ ] No

Were you knocked unconscious? [ ] Yes [ ] No
If yes, for how long?.________________

You were struck from [ ] Behind [ ] Front [ ] Left side [ ] Right side

You were [ ] 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?____

Was any other doctor consulted after your accident? [ ] Yes [ ] No

If so, what was the doctor's name?____________________________________

What was the diagnosis?____

What treatment was given?____

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 YES, what were the complaints?____________________________________

Before the injury were you capable of working on an equal basis with others 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? [ ] Same?

By my signature I attest that all of the above information is true

Signature____ Date____________