

# 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 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 you 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	ADDRESS	CITY	STATE	ZIP
OCCUPATION								
SOC. SEC. #			BUSINESS PHONE			WHO REFERRED YOU TO OUR OFFICE? (Indicate if child, student, housewife, unemployed, retired)		
SPOUSE'S FIRST NAME			SPOUSE'S SOC. SEC. #			SPOUSE'S EMPLOYER		
DRIVER OF OTHER VEHICLE (IF ANY)			INSURANCE COMPANY			POLICY NUMBER		
DRIVER OF VEHICLE IN WHICH YOU WERE INJURED (IF APPLICABLE)			INSURANCE COMPANY			POLICY NUMBER		
NAME OF YOUR INSURANCE ADJUSTOR								
HAVE YOU RETAINED AN ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO								

Please explain in detail how your accident happened:

What were the time and date of present injury?

Where did you feel pain immediately after the accident?

List the extent of injuries as you know them:

Did you require post accident hospitalization?  YES  NO

## CURRENT COMPLAINT

NAME	CHART #	TODAY'S DATE	DOCTOR
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What is your current complaint? (Why are you seeking treatment?)

How severe is this problem? <input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately Severe <input type="checkbox"/> Severe	How Frequently? <input type="checkbox"/> Constant <input type="checkbox"/> Occasional <input type="checkbox"/> Intermittent <input type="checkbox"/> Frequent	On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	Select each choice that applies to you Movement <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Inflexibility <input type="checkbox"/> Restricted Movement <input type="checkbox"/> Spasm Sensation <input type="checkbox"/> Crawling <input type="checkbox"/> Dead <input type="checkbox"/> Numb <input type="checkbox"/> Prickly <input type="checkbox"/> Tingling <input type="checkbox"/> Pins and needles
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When was the onset of this problem?

<input type="checkbox"/> gradual <input type="checkbox"/> sudden <input type="checkbox"/> insidious	<input type="checkbox"/> about a day ago <input type="checkbox"/> several days ago <input type="checkbox"/> about a week ago <input type="checkbox"/> several weeks ago <input type="checkbox"/> about a month ago	<input type="checkbox"/> several months ago <input type="checkbox"/> about a year ago <input type="checkbox"/> several years ago	Please indicate everything that makes you feel better <input type="checkbox"/> usually better in the morning <input type="checkbox"/> usually better during the day <input type="checkbox"/> usually better at night
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<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately Severe <input type="checkbox"/> Severe	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional <input type="checkbox"/> Intermittent <input type="checkbox"/> Frequent	On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	Select the type of pain that best describes your complaint <input type="checkbox"/> Achy <input type="checkbox"/> Numb ache <input type="checkbox"/> Burning <input type="checkbox"/> Pounding <input type="checkbox"/> Dull <input type="checkbox"/> Pulsating <input type="checkbox"/> Excruciating <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Stinging <input type="checkbox"/> Throbbing
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Please indicate everything that makes you feel worse or aggravates your condition  
 usually worse in the morning  usually worse during the day  usually worse at night

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_

### AUTOMOBILE ACCIDENT

NAME \_\_\_\_\_ CHART # \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_ ACCIDENT DATE \_\_\_\_\_

#### DESCRIBE THE VEHICLE

<b>Position in vehicle</b> <input type="checkbox"/> Driver <input type="checkbox"/> Front mid passenger <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Rear mid passenger <input type="checkbox"/> Rear right passenger	<b>Vehicle Size</b> <input type="checkbox"/> Mini <input type="checkbox"/> Sub-compact <input type="checkbox"/> Compact <input type="checkbox"/> Full-Size <input type="checkbox"/> Light <input type="checkbox"/> Mid-Size	<b>Patient's Vehicle Type</b> <input type="checkbox"/> Bus <input type="checkbox"/> Sports Car <input type="checkbox"/> Coupe <input type="checkbox"/> Sedan <input type="checkbox"/> Station Wagon <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Pick-up truck <input type="checkbox"/> Sport-utility
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#### DESCRIBE THE ACCIDENT

<b>Action of patient vehicle</b> <input type="checkbox"/> Crossing intersection <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped for pedestrian <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Turning right <input type="checkbox"/> Turning left <input type="checkbox"/> Travelling speed limit <input type="checkbox"/> Faster than speed limit <input type="checkbox"/> Slower than speed limit	<b>Patient's vehicle was hit</b> <input type="checkbox"/> Head-on <input type="checkbox"/> On the left front <input type="checkbox"/> On the right front <input type="checkbox"/> On the left rear <input type="checkbox"/> On the right rear <input type="checkbox"/> Was rear-ended <input type="checkbox"/> Sideswiped on left <input type="checkbox"/> Sideswiped on right	<b>Patient's vehicle hit by</b> <input type="checkbox"/> A compact car <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A full-sized van <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A mini-van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A semi-trailer <input type="checkbox"/> A light truck <input type="checkbox"/> None of the above	<b>Weather Conditions</b> <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Drizzling <input type="checkbox"/> Foggy <input type="checkbox"/> Rainy <input type="checkbox"/> Snowing <input type="checkbox"/> Storming <input type="checkbox"/> Sunny	<b>Road Conditions</b> <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Iced over <input type="checkbox"/> Dry with icy patches <input type="checkbox"/> Snowed over
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#### DESCRIBE MOMENT OF IMPACT

<b>Body position at impact</b> <input type="checkbox"/> Leaning forward <input type="checkbox"/> Slouched in seat <input type="checkbox"/> Straight <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	<b>Head position at impact</b> <input type="checkbox"/> Straight <input type="checkbox"/> Tilted forward <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	<b>Type of Passive Restraint</b> <input type="checkbox"/> Airbag <input type="checkbox"/> Lap belt <input type="checkbox"/> Shoulder-tap belt	<b>Did you brace for impact?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Direction body was thrown</b> <input type="checkbox"/> Forward then back <input type="checkbox"/> To the right <input type="checkbox"/> Outside the vehicle	<b>Direction head was thrown</b> <input type="checkbox"/> Back then forward <input type="checkbox"/> Forward then back <input type="checkbox"/> Side to side
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I understand that the information I have provided above is current and complete to the best of my knowledge.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_

Date \_\_\_\_\_