

# 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 \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_  
(Indicate if child, student, housewife, unemployed, retired)  
Social Business Company  
Sec. # Phone Name Location  
Spouse's Spouse's Spouse's  
First Name Soc. Sec. # Employer Location

Please explain in detail how your accident happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_  
Driver of other vehicle (if any)

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_  
Driver of vehicle in which you were injured (if applicable)

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his name and address \_\_\_\_\_

You were 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? \_\_\_\_\_

You were struck from  Behind  Front  Left side  Right side

You were  Driver  Passenger  Front seat  Back seat  Using seat belts  Other protective devices

What were the time and date of present injury? \_\_\_\_\_

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? \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S.

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 so, 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?

**HEALTH QUESTIONNAIRE:**

Please indicate for each of the questions below your experience by use of the following codes: 1—never had; 2—previously had; 3—presently have.

**MUSCULO-SKELETAL SYSTEM**

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

**GENITO-URINARY SYSTEM**

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

**FEMALE**

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
  - Yes
  - No

**GASTRO-INTESTINAL SYSTEM**

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

**NERVOUS SYSTEM**

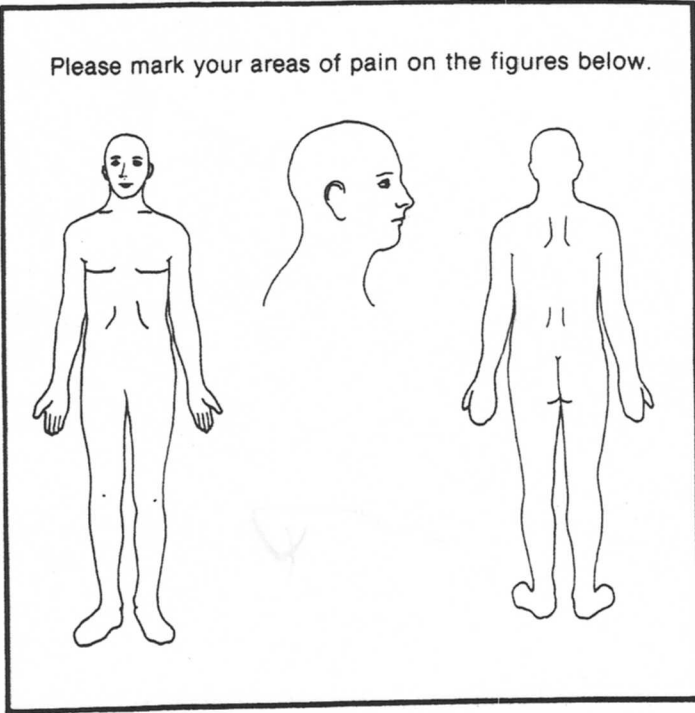
- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

**CARDIO-VASCULAR-RESPIRATORY**

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose Veins

**EYE, EAR, NOSE, AND THROAT**

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech



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

..... DO NOT WRITE BELOW THIS LINE .....

.....  
.....  
.....  
.....  
.....  
.....  
Patient accepted? Yes \_\_\_\_\_ No \_\_\_\_\_ Doctor's signature \_\_\_\_\_