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 Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's 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

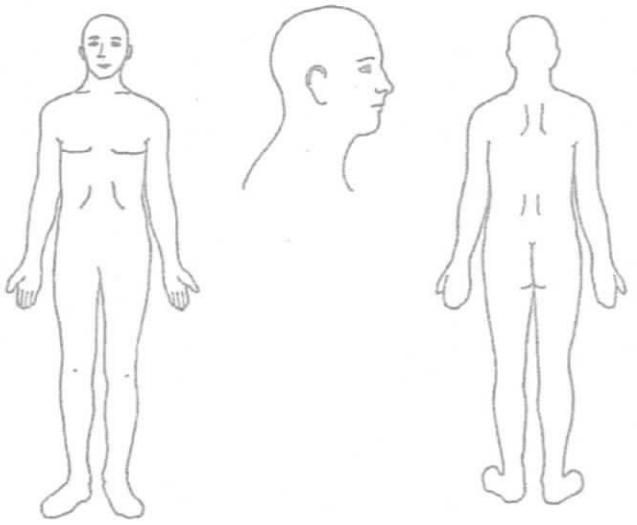
____ Bladder trouble
____ Excessive urination
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

Are you pregnant?
____ Yes ____ No

Please mark your areas of pain on the figures below.



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 Date

DO NOT WRITE BELOW THIS LINE

Patient accepted? Yes____ No____ Doctor's signature____