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 your condition properly, please be as neat and accurate as posssible while completing this form. Thank you.

Name_____Sex_____ _ Marital Status _____ Date of Birth _____ Home Phone _____

Address_____City_____State_____

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 _____

Your insurance company_____Policy No._____Claim No._____

In which state did accident occur?_____

Please explain in detail how your accident happened_____

_____

_____

_____

_____

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

Have you lost time from work as a result of this accident? • Yes • No

If yes, please complete: Last day worked_____

Place & type of employment_____

Since this injury are your symptoms • improving? • getting worse? • the same?

HEALTH QUESTIONNAIRE:

Symptoms I've had since accident_____

_____

_____

_____

_____

_____

Symptoms I had before accident_____

_____

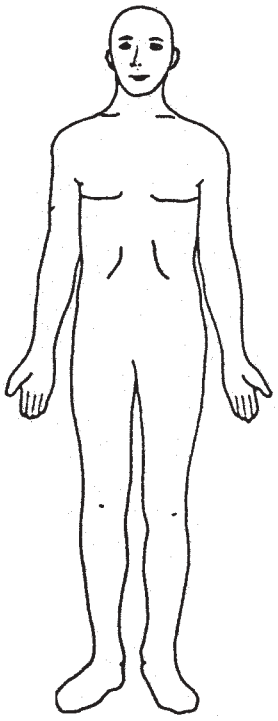
_____

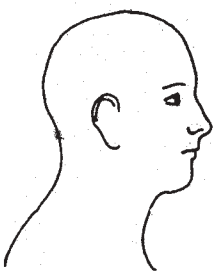
_____

_____

_____

Please mark your areas of pain on the figures below.





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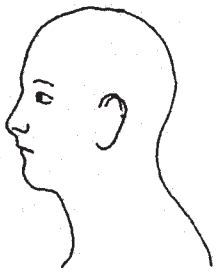

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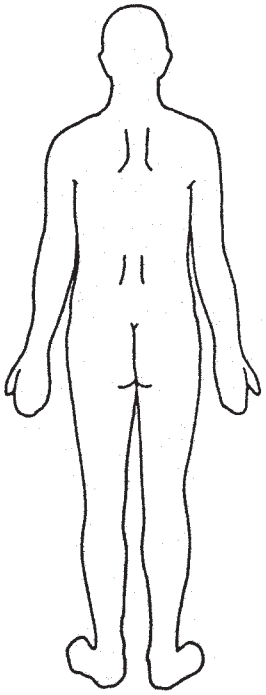

_____

Patient's Signature

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

Patient accepted? # Yes # No Doctor's Signature_____