VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last First Middle | HOME PHONE | DATE

ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | AGE | BIRTH DATE | SEX | MARITAL STATUS | NO. OF CHILDREN

EMPLOYER | ADDRESS | BUSINESS PHONE

OCCUPATION | WHO REFERRED YOU TO OUR OFFICE?

INSURANCE INFORMATION

YOUR INSURANCE COMPANY | POLICY NO. | CLAIM NO.

NAME OF OTHER VEHICLE'S DRIVER | OTHER VEHICLE'S INSURANCE COMPANY | POLICY NO.

NAME OF YOUR VEHICLE'S DRIVER | YOUR VEHICLE'S INSURANCE COMPANY | POLICY NO.

NAME OF YOUR INSURANCE ADJUSTER PHONE

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:

DATE AND TIME OF ACCIDENT: ☐ A.M. ☐ P.M. | WERE POLICE NOTIFIED? ☐ Yes ☐ No

YOUR VEHICLE WAS HEADING:

☐ North ☐ South ☐ East ☐ West ON: ☐ Street ☐ Highway

OTHER VEHICLE WAS HEADING:

☐ North ☐ South ☐ East ☐ West ON: ☐ Street ☐ Highway

YOUR VEHICLE WAS STRUCK FROM THE:

☐ Front ☐ Back ☐ Driver's Side ☐ Passenger's Side

YOU WERE: ☐ Driver ☐ Front Seat ☐ Passenger ☐ Back Seat

WERE YOU USING A SEAT BELT? ☐ Yes ☐ No

WERE YOU UNCONSCIOUS? IF YES, HOW LONG?

☐ No ☐ Yes ►

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?

EXACT AREA(S) OF PAIN IMMEDIATELY AFTER ACCIDENT:

WHAT TREATMENT WAS GIVEN?

WHAT DIAGNOSIS WAS GIVEN?

DOCTOR'S NAME: | HOW OFTEN DID YOU SEE THIS DOCTOR?

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS & PHONE:

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE

☐ No ☐ Yes ►

HAVE YOU RETAINED AN ATTORNEY? IF YES, GIVE NAME, ADDRESS & PHONE

☐ No ☐ Yes ►

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?

☐ No ☐ Yes ►

BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?

☐ Yes ☐ No

SINCE THIS INJURY, ARE YOUR SYMPTOMS:

☐ Improving ☐ The Same ☐ Getting Worse

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HEALTH SURVEY

Please describe your injuries and symptoms resulting from this accident:

What medication(s) did you take?

Are you still taking medication(s)? ☐ Yes ☐ No

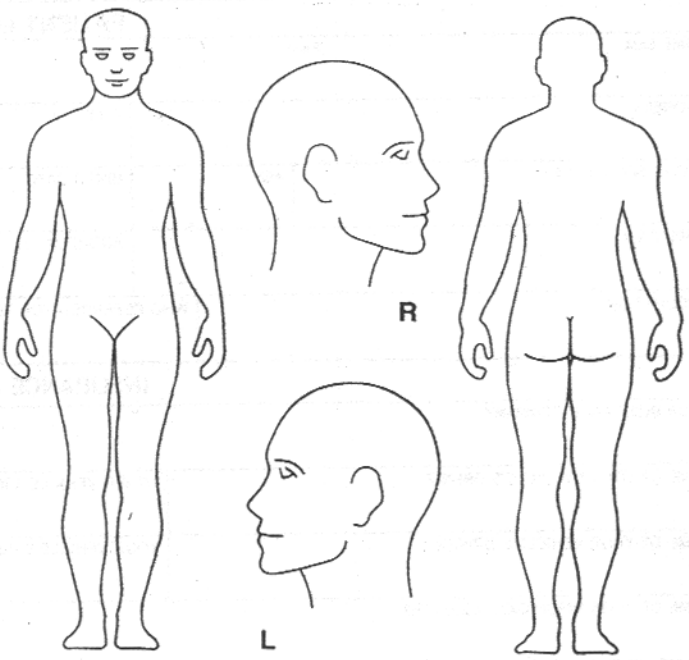
If yes, how often and how much?

Did you return to work? ☐ Yes ☐ No

If no, how long were you off work?

If yes, were there any restrictions or limitations?

Mark areas of pain resulting from this accident on figures below:



Please mark the degree of all conditions which you have, or have had. Use the following letters to rate your conditions:

O = Occasional
F = Frequent
C = Constant

GASTRO-INTESTINAL

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

NERVOUS SYSTEM

_____ Dizziness
_____ Fainting
_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Headaches
_____ Convulsions
_____ Muscle spasms
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR

_____ Chest pain
_____ Rapid heartbeat
_____ Heart problems
_____ Pain over heart
_____ Blood pressure problems
_____ Varicose veins
_____ Lung problems
_____ Coughing phlegm
_____ Coughing blood
_____ Persistant cough
_____ Difficult breathing

EYE, EAR, NOSE & THROAT

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

GENITO-URINARY

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

FEMALE

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

Are you pregnant?
☐ Yes ☐ No

MUSCULO-SKELETAL

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

Patient's Signature:
(If a minor, parent's or guardian's signature) _____ Date: _____

Doctor's Signature: _____ Date: _____