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 possible while completing this form. Thank you.

Name ______ Sex ______ Marital Status ______ Date of Birth ______
Address ______ City ______ State ______ ZIP ______
Home Phone ______ Cell Phone ______ E-mail ______
Soc.Sec. # ______ Occupation ______ Employer ______
(Indicate if child, student, housewife, unemployed, retired)
Company Name ______ Location ______ Work Phone ______
Spouse's First Name ______ Spouse's Soc.Sec.# ______ Spouse's Employer ______
Who referred you to our office? ______

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
Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach Upset	☐ Light Bothers Eyes	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Fainting	☐ Sleeping Problems	☐ Loss of Balance	☐ Back Pain
☐ Face Flushed	☐ Pins and Needles in Legs	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in Fingers	☐ Loss of Smell	☐ Fever
☐ Irritability	☐ Numbness in Toes	☐ Loss of Taste	☐ Chest Pain
☐ Cold Sweats	☐ Shortness of Breath	☐ ______	☐ ______

Symptoms other than above: ______

Where were you taken after the accident? ______
Hospitalized? ☐ Yes ☐ No If yes, admitted? ______ How long? ______
Name of Hospital ______
Name of Doctors ______
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?

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)

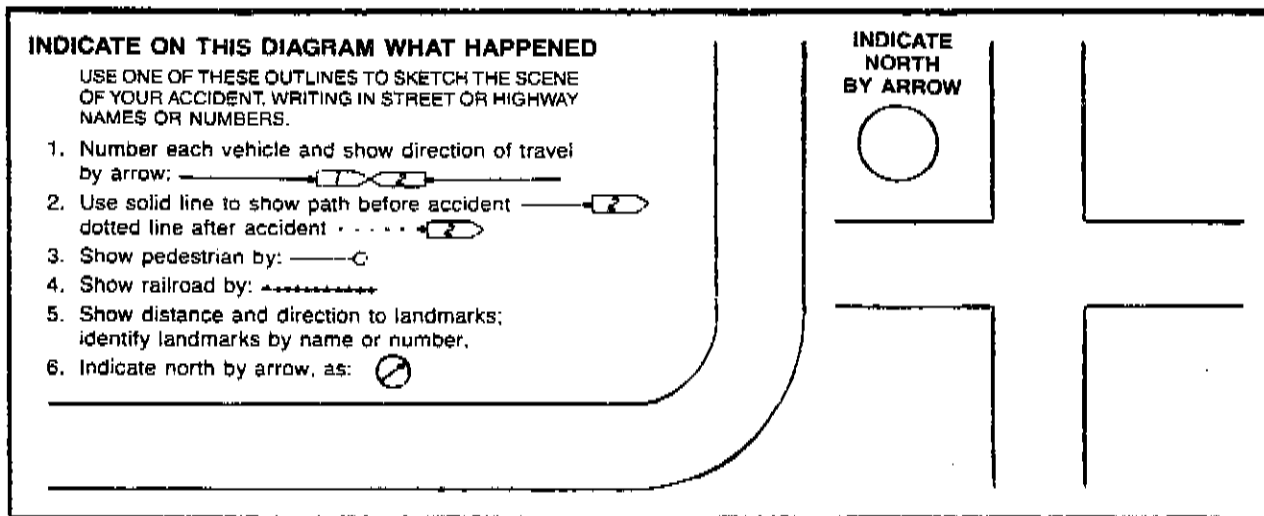
Other vehicle was heading ☐ North ☐ East ☐ South ☐ West on ________________(street or highway)

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



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________________

I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo treatment and I hereby give my consent for treatment.

Signature ________________ Date ________________

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

Patient accepted? ☐ Yes ☐ No Doctor's Signature________________