

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
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:	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WERE POLICE NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Driver's Side <input type="checkbox"/> Passenger's Side	YOU WERE: <input type="checkbox"/> Driver <input type="checkbox"/> Front Seat <input type="checkbox"/> Passenger <input type="checkbox"/> Back Seat	WERE YOU USING A SEAT BELT? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	---

WERE YOU UNCONSCIOUS? IF YES, HOW LONG? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	SINCE THIS INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> Improving <input type="checkbox"/> The Same <input type="checkbox"/> Getting Worse
---	--

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:

