Automobile Accident Questionnaire

Please answer all questions completely

This information is considered confidential. Your answers will help us determine if chiropractic can help you and your health condition. If we do not sincerely believe your condition will respond sufficiently, we will not accept your case. In order for us to understand your condition, please be as accurate as possible in completing this form. Thank you.

Name_____________________________________ Sex______ Date of Birth______________Social Sec.#________________________
Address____ City_____________________________ State____________ Zip____________
Phone______________________ Occupation______________________________________*(Indicate if child, student, housewife, unemployed, retired)
Employer______________________________ Location_____________________ Business Phone______________________________
Marital Status_____ Spouse's First Name____________________________________ Spouse's Employer_______________________

Who referred you to our office?____________________________________

Please explain in detail how your accident happened
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Insurance Company___________________________________ 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 adjuster____ Have you retained an attorney? □ YES □ NO
If so, 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 yes, 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 was 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 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?

Date:___________________________ Patient's Signature____