AUTOMOBILE ACCIDENT QUESTIONNAIRE

NAME_____SOCIAL SECURITY#_____

ADDRESS_____CITY_____STATE_____ ZIP_____

WORK/CELL PHONE_____HOME PHONE_____AGE_____ Date of Birth_____

OCCUPATION _____MARITAL STATUS: **M S W D** CHILDREN_____

DATE OF ACCIDENT_____TIME OF ACCIDENT_____LOCATION_____

AT THE TIME OF THE ACCIDENT YOU WERE THE: *(***PLEASE CIRCLE)** **DRIVER** **FRONT SEAT PASSENGER**

Right/Left/Middle BACK SEAT PASSENGER **PEDESTRIAN** **MOTORCYCLE** **BICYLCE** **OTHER**

DID YOU HAVE YOUR SEATBELT ON AT THE TIME OF THE ACCIDENT? **YES** **NO**

WERE YOU AWARE OF THE IMPENDING COLLISION AND DID YOU ATTEMPT TO BRACE? **YES** **NO**

WHAT WHERE THE ROAD CONDITIONS? **WET** **DRY** **SNOW** **ICE**

DID ANY AIRBAGS DEPLOY? **YES** **NO** WERE YOU KNOCKED UNCONSCIOUS? **YES** **NO**

DID YOU STRIKE YOUR HEAD OR OTHER BODY PARTS WITHIN THE VEHICLE? **YES** **NO**

IF YES, WHAT AND WHERE?_____

PLEASE EXPLAIN HOW THE ACCIDENT OCCURRED: _____

_____

_____

_____

_____

PLEASE LIST YOUR PAIN OR SYMPTOMS AS A RESULT OF THIS ACCIDENT: _____

_____

_____

DID YOU GO TO A HOSPITAL OR DOCTOR? IF SO, WHERE AND WHEN?_____

HOW DID YOU GO TO THE HOSPITAL OR DOCTOR? **AMBULANCE** **DROVE SELF** **DRIVEN** **OTHER**

AT THE HOSPITAL OR DOCTOR WHAT TREATMENT WAS GIVEN?_____

_____

DID YOU MISS ANY TIME FROM WORK? **YES** **NO** IF YES, HOW LONG? _____

SINCE THE ACCIDENT ARE YOUR SYMPTOMS: **IMPROVING** **WORSE** **SAME**

WHAT POSITIONS OR ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT POSITIONS OR ACTIVITIES RELIEVE YOUR CONDITION?_____

IS YOUR CURRENT CONDITION SOLELY A RESULT OF THIS ACCIDENT? **YES** **NO**

IF NO, PLEASE EXPLAIN_____

HAVE YOU BEEN INVOLVED IN ANY PREVIOUS AUTO ACCIDENTS? **YES** **NO** IF YES, WHEN? AND NOTE THE

INJURIES THAT RESULTED?_____

_____

LIST ALL MEDICATIONS/VITAMINS THAT YOU ARE NOW TAKING AND WHAT FOR:_____

_____

CHECK ANY SIGNIFICANT SYMPTOMS THAT YOU CURRENTLY EXPERIENCE OR HAVE EXPERIENCED

GENERAL
( ) ALLERGY
( ) CHILLS
( ) CONVULSION
( ) DIZZINESS
( ) FAINTING
( ) FEVER
( ) HEADACHE
( ) LOSS OF SLEEP
( ) LOSS OF WEIGHT
( ) NERVOUSNESS
( ) DEPRESSION
( ) SWEATS
( ) TREMORS

GASTRO-INTESTINAL
( ) CONSTIPATION
( ) DIARRHEA
( ) DIGESTIVE PROBLEMS
( ) GALL BLADDER PROBLEMS
( ) HEMORRHOIDS
( ) LIVER PROBLEMS
( ) NAUSEA
( ) STOMACH PAIN
( ) POOR APPETITE
( ) VOMITING
( ) VOMITING BLOOD
( ) COLON TROUBLE

MUSLCE & JOINT
( ) LOW BACK PAIN
( ) MUSCLE SPASMS
( ) NECK PAIN
( ) MID/UPPER BACK PAIN
( ) SWOLLEN JOINTS
PAIN/NUMBNESS IN THE:
( ) SHOULDERS
( ) ARMS
( ) ELBOWS
( ) HANDS
( ) HIPS
( ) LEGS
( ) KNEES
( ) FEET

SKIN
( ) BOILS
( ) BRUISE EASILY
( ) COLD SORES
( ) DRYNESS
( ) RASHES/HIVES
( ) VARICOSE VEINS

RESPIRATORY
( ) CHRONIC COUGH
( ) DIFFICULTY BREATHING
( ) COUGHING UP BLOOD
( ) COUGHING UP PHLEGM
( ) WHEEZING

EAR-NOSE-THROAT
( ) FREQUENT COLDS
( ) EARACHE
( ) EAR NOISES
( ) EYE DISCHARGE
( ) POOR VISION
( ) NOSE BLEEDS
( ) SINUS TROUBLE
( ) DEAFNESS
( ) EAR DISCHARGE
( ) ENLARGED GLANDS
( ) EYE PAIN
( ) DENTAL PROBLEMS
( ) NASAL OBSTRUCTION
( ) LARYNGITIS

GENITO-URINARY
( ) BED WETTING
( ) BLOOD IN URINE
( ) FREQUENT URINATION
( ) KIDNEY INFECTION
( ) PAINFUL URINATION
( ) PUS IN URINE
( ) KIDNEY PROBLEMS

CARDIOVASCULAR
( ) CHEST PAIN
( ) ARTERIOSCLEROSIS
( ) HIGH BLOOD PRESSURE
( ) LOW BLOOD PRESSURE
( ) POOR CIRCULATION
( ) RAPID HEAR BEAT
( ) SLOW HEART BEAT

HABITS
( ) ALCOHOL – AMOUNT PER DAY/HOW MANY YEARS? _____
( ) TOBACCO – AMOUNT PER DAY/HOW MANY YEARS?_____
( ) DRUGS - AMOUNT PER DAY HOW MANY YEARS?_____
( ) EXERCISE – AMOUNT PER WEEK_____

ARTIFICIAL PROSTHESES
( ) DENTURES
( ) CONTACT LENSES
( ) HEARING AID
( ) SURGICAL IMPLANTS

WOMEN ONLY ARE YOU PREGNANANT? **YES NO** IS THERE A CHANCE OF YOU BEING PREGNANT? **YES NO**

NOTE ANY PRIOR DISEASES OR CONDITIONS THAT HAVE BEEN DIAGNOSED (Such as Diabetes, high blood pressure, etc.)

_____

HAVE YOU HAD ANY PRIOR SURGIES OR HOSPITILIZATIONS? **YES NO** IF YES, WHEN AND FOR WHAT?

_____

_____

NOTE ANY FAMILY HISTORY OF DISEASE OR ILLNESS (Heart Disease, Cancer, ETC.)_____

_____

INSURANCE INFORMATION

AUTO INSURANCE _____ POLICY/CLAIM#_____

PERSONAL HEALTH INSURANCE_____ ID#_____

I understanding 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. For certain personal health policies this may include services not payable per my personal health insurance policy, however allowable per my personal health insurance policy to be performed and charged to me.

PATIENTS SIGNATURE_____ DATE_____