AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name _____ File #_____

Time and date of accident?_____ Place of accident (street, town)_____
Immediately after the accident where did you feel pain? _____
List the extent of injuries, as you know them:_____

_____

Where were you taken after the accident?_____

Hospitalized? Yes No If yes, admitted?_____ How long?_____
Name of Hospital and doctors_____

_____

What treatment was given?_____

_____

Was any other doctor consulted after your accident? Yes No
Name of doctor(s)_____D.C., M.D., D.O., D.D.S (Circle one)
What was the diagnosis?
What treatment was given?_____

_____

How often and for how long did you see the doctor?_____

_____

Tests performed? X-rays MRI CT SCAN EMG Other

Check the 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		

Did you have any of these symptoms before the accident? If yes Please explain.

_____

_____

Were you knocked unconscious? Yes No
You were struck from? (circle one) behind front left side right side
You were? (circle one) Driver Passenger Front seat Back seat
Using seatbelt other protective device?

Is there anything else you would like the doctor to know about this accident? _____

_____

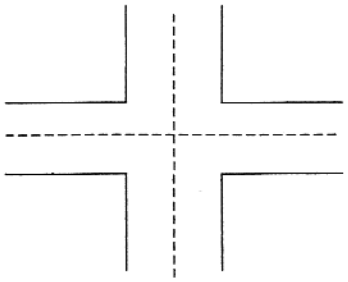
Describe how the accident happened in detail_____

_____

_____

_____

_____



On the diagram please indicate where your vehicle was traveling, along with any other vehicles involved.

Name and phone number of your insurance adjustor_____

Name and address of attorney (if any)_____

_____

Were police notified? Yes _____ No_____

Were you injured as a result of the accident? Yes_____ No_____

At the time of the accident were you in the course of your employment? Yes/No

Driver's Name_____Insurance Co._____

Policy No._____

Driver of other vehicle_____Insurance Co._____

Policy No._____

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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.

Patients Signature: _____Date_____

Guardian or Spouse's Signature: _____Date_____