

# 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:  A.M.  P.M. WERE POLICE NOTIFIED?  Yes  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:  Front  Back  Driver's Side  Passenger's Side YOU WERE:  Driver  Front Seat  Passenger  Back Seat WERE YOU USING A SEAT BELT?  Yes  No

WERE YOU UNCONSCIOUS? IF YES, HOW LONG?  No  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?  Yes  No SINCE THIS INJURY, ARE YOUR SYMPTOMS:  Improving  The Same  Getting Worse

# HEALTH SURVEY

Please describe your injuries and symptoms resulting from this accident:

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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

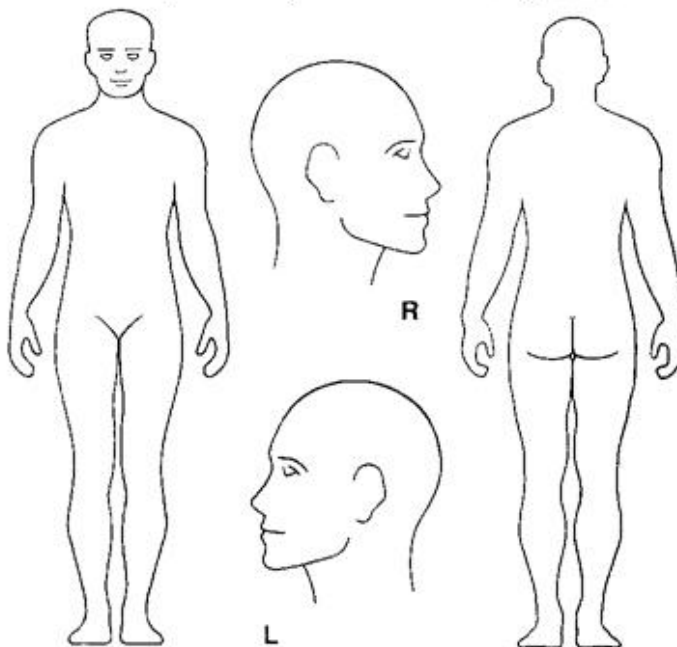
If no, how long were you off work?

If yes, were there any restrictions or limitations?

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Mark areas of pain resulting from this accident on figures below:



Please mark the degree of all conditions which you have, or have had. Use the following letters to rate your conditions:

**O** = Occasional  
**F** = Frequent  
**C** = Constant

### NERVOUS SYSTEM

- Dizziness
- Fainting
- Numbness
- Loss of feeling
- Paralysis
- Headaches
- Convulsions
- Muscle spasms
- Forgetfulness
- Confusion
- Depression

### CARDIO-VASCULAR

- Chest pain
- Rapid heartbeat
- Heart problems
- Pain over heart
- Blood pressure problems
- Varicose veins
- Lung problems
- Coughing phlegm
- Coughing blood
- Persistent cough
- Difficult breathing

### EYE, EAR, NOSE & THROAT

- Eye strain
- Vision problems
- Eye infection
- Hearing loss
- Ear noises
- Ear pain
- Ear discharge
- Nose bleeding
- Nose discharge
- Nose pain
- Difficult nose breathing
- Difficult speech
- Dental problems
- Sore gums
- Sore mouth
- Sore throat
- Hoarseness

### GENITO-URINARY

- Bladder trouble
- Painful urination
- Discolored urine
- Scanty urination
- Excessive urination

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast

Are you pregnant?

Yes  No

### MUSCULO-SKELETAL

- Low back problems
- Neck problems
- Pain between shoulders
- Arm problems
- Leg problems
- Painful joints
- Stiff joints
- Swollen joints
- Sore muscles
- Weak muscles
- Broken bones
- Ruptures
- Walking problems

### GASTRO-INTESTINAL

- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Diarrhea
- Constipation
- Bloody stool
- Black stool
- Hemorrhoids
- Weight trouble
- Liver trouble
- Gall bladder trouble

Patient's Signature: \_\_\_\_\_  
 (If a minor, parent's or guardian's signature)

Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_