Auto Accident Questionnaire

This form will be retained in your medical record

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Today's date: _______________

Name: ____ M / F Date of Birth: _________________

1. Date of accident: ______________ Time of accident: ______________ (AM / PM)
2. Who was the driver of the car? ___________________________________ Relationship: _________________________
3. Where in the car were you seated? ____
4. Type of accident: Head-on collision / Broad side collision / Rear-end collision / Front impact, rear-ended car in front / Non-collision: (*please describe*) ____
5. Describe in your own words what happened to you upon impact: ____
6. Did you brace for impact? Yes / No
7. Were you wearing a seat belt? Yes / No Was it a shoulder harness? Yes / No
8. Does the car you were in have headrests? Yes / No

   If yes, what was the position of the headrest compared to your head before the accident?

   Top of headrest even with BOTTOM of head
   Top of headrest even with TOP of head
   Top of headrest even with MIDDLE OF NECK
9. Was your car moving at the time of the accident? Yes / No

   If yes, how fast would you estimate that you were going? __________ mph
   If yes, was your car braking at time of impact? Yes / No
10. How fast would you say the other car was going? __________ mph
11. What was your head and body position at the time of impact?

    Head was: turned left / right; looking back; straight forward
    Body was: straight in sitting position; rotated left / right; other: ____________________________
12. At time of impact, what parts of your head or body hit what parts on the inside of the car: __________________________
13. Were you knocked unconscious? Yes / No

    If yes, for how long? ____
14. Could you move all parts of your body? Yes / No

    If no, what parts and why? ____
15. Were you able to get out of the car and walk unaided? Yes / No

    If no, why not? ____
16. Please be specific and describe how you felt:

    Immediately after the accident: ____

    Later that day: ____

    The next day(s): ____

17. Check symptoms you have noticed SINCE your accident:

Headache	Dizziness	Depression	Fatigue
Upset stomach	Light bothers eyes	Buzzing in ears	Diarrhea
Neck pain	Head seems too heavy	Ringing in ears	Cold feet
Neck stiff	Pins and needles in arms	Loss of memory	Cold hands
Fainting	Pins and needles in legs	Loss of balance	Back pain
Flushed face	Sleeping problems	Loss of smell	Tension
Nervousness	Numbness in Fingers	Loss of Taste	Fever
Irritability	Numbness in Toes	Constipation	Chest Pain
Cold sweats	Shortness of breath	Other: ____________________	

18. Did you seek medical help immediately or soon after the accident? Yes / No

If yes, how did you get there? Someone else drove me / Ambulance / I drove my own car / Police / Other: ____________________

Doctor / Hospital / Clinic seen: ____________________ Date: ____________

Were x-rays taken? If yes, what body parts? ____________________

What treatment was given to you? ____________________

How often did you see the doctor? ____________________

Date of last treatment: ____________

19. Have you missed time from work or school because of this accident? Yes / No

If yes, Unable to work or go to school since accident

Full-time off work. Dates: ________ to ________ and ________ to ________

Part-time off work. Dates: ________ to ________ and ________ to ________

20. Did you have any physical complaints just before the accident? Yes / No

If yes, please describe in detail: ____________________

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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 Chiropractic Arts Clinic 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 Chiropractic Arts Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

____________________ ____________________
Patient signature (or legally authorized individual) Date

____________________ ____________________
Printed name of authorized individual Relationship (parent, POA, caretaker, etc.)

____________________ ____________________
Authorized Clinic Employee signature Date