

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Patient Details (Please use print)

Name		Contact Ph:	
Address	City	State	Zip
Married	Sex	DOB	
Occupation	Who referred you?		

(please indicate if child, student, housewife, unemployed, retired)

Social Sec.#	Business Phone	Company Name	Location
Spouses First Name	Spouses Social Sec.#	Spouses Employer	Location

Please explain in detail how your accident happened:	

Insurance Company:		
Policy No.:		Claim No.:
Driver of other vehicle (if any)		
Insurance Company:		Policy No.:
Driver of vehicle in which you were injured (if applicable):		
Insurance Company:		Policy No.:
Name of insurance adjuster:		

Have you retained an attorney? Yes No

If so, his name, address and telephone: _____

Accident Details

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 so, for how long? _____

You were struck from Behind Front Left side Right side

You were Driver Passenger Front seat Backseat Using seat belts Other protective devices

What were 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.S

What was the diagnosis? _____

What treatment was given? _____

How often did you see the 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

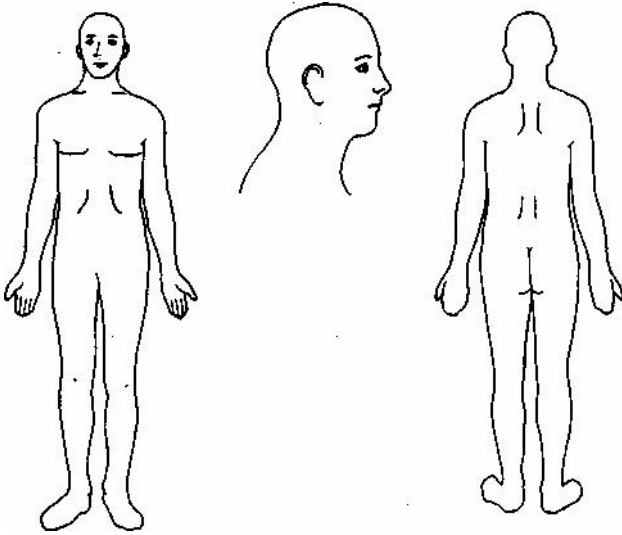
Since this injury are your symptoms Improving? Getting worse? Same?

Other information: _____

Health Questionnaire

Please indicate for each of the questions below your experience by use of the following codes:

1—never had; 2—previously had; 3—presently have.

MUSCULO-SKELETAL SYSTEM	GENITO-URINARY SYSTEM	GASTROINTESTINAL SYSTEM	CARDIO-VASCULAR-RESPIRATORY
Low back problems	Bladder trouble	Poor appetite	Chest pain
Pain between shoulders	Excessive urination	Excessive hunger	Pain over heart
Neck problems	Scanty urination	Difficult chewing	Difficult breathing
Arm problems	Painful urination	Difficult swallowing	Persistent cough
Leg problems	Discolored urine	Excessive thirst	Coughing phlegm
Swollen joints	FEMALE	Nausea	Coughing blood
Painful joints	Vaginal discharge	Vomiting food	Rapid heartbeat
Stiff joints	Vaginal bleeding	Vomiting blood	Blood pressure problems
Sore muscles	Vaginal pain	Abdominal pain	Heart problems
Weak muscles	Breast pain	Diarrhea	Lung problems
Walking problems	Lumps on breast	Constipation	Varicose Veins
Ruptures	Are you pregnant?	Black stool	EYE, EAR, NOSE, AND THROAT
Broken bones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bloody stool	
Please mark your areas of pain on the figures below 		Hemorrhoids	Eye inflammation
		Liver trouble	Vision problems
		Gall bladder problems	Ear pain
		Weight trouble	Ear noises
		NERVOUS SYSTEM	Ear discharge
		Numbness	Hearing loss
		Loss of feeling	Nose pain
		Paralysis	Nose bleeding
		Dizziness	Nose discharge
		Fainting	Difficult breathing thru nose
		Headaches	Sore gums
		Muscle jerking	Dental problems
		Convulsions	Sore mouth
		Forgetfulness	Sore throat
		Confusion	Hoarseness
Depression	Difficult speech		

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release my information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of Patient (or parent if a minor)

Date