

Automobile Accident Questionnaire

2 SIDE

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.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)
Social Business Company
Sec. # _____ Phone _____ Name _____ Location _____
Spouse's Spouse's Spouse's
First Name _____ Soc. Sec. # _____ Employer _____ Location _____

Please explain in detail how your accident happened _____

Insurance Co. _____ Policy No. _____ Claim No. _____

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____
Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes No

If so, his name and address _____

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 Back seat 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.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?

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

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

GENITO-URINARY SYSTEM

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

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes No

GASTRO-INTESTINAL SYSTEM

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

NERVOUS SYSTEM

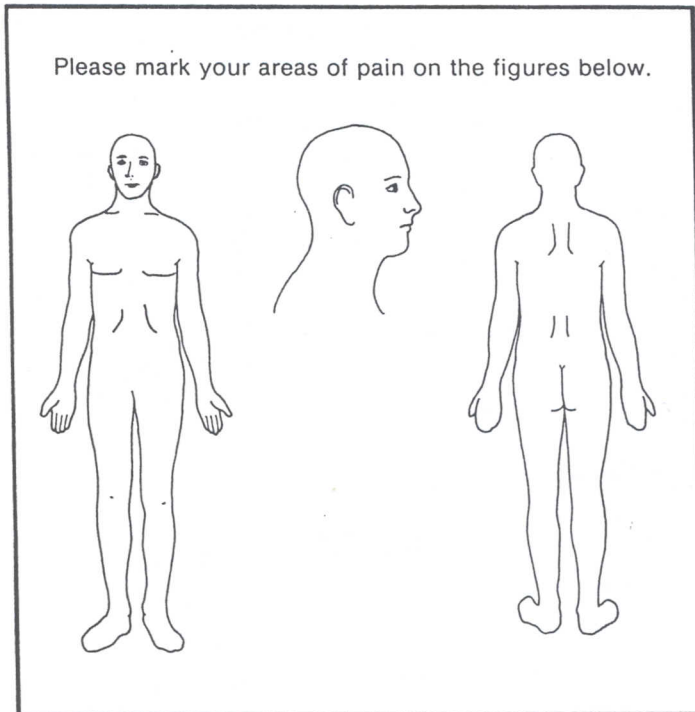
- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

CARDIO-VASCULAR-RESPIRATORY

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

EYE, EAR, NOSE, AND THROAT

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



Patient's Signature

..... DO NOT WRITE BELOW THIS LINE

Patient accepted? Yes _____ No _____ Doctor's signature _____