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.

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 Sec. #__________________ Business Phone_________________ Company Name______________Location _____________

Spouse's First Name ______________ Spouse's Soc. Sec.#______________ Spouse's 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 hwy)

Other vehicle was headed ____ North ____ East ____South ____ West on ______________(street or hwy)

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 ____seat belts ____ other protective devices

What were the time and date of present injury? ____

Where did you feel pain after the accident? ____

Where were you taken after the accident? ____

What treatment was given? ____

Was any other doctor consulted after you accident? ____ yes ____ no

If so, what was the doctor's name? _________________________ ____DC ____ MD ____DO ____ DDS

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

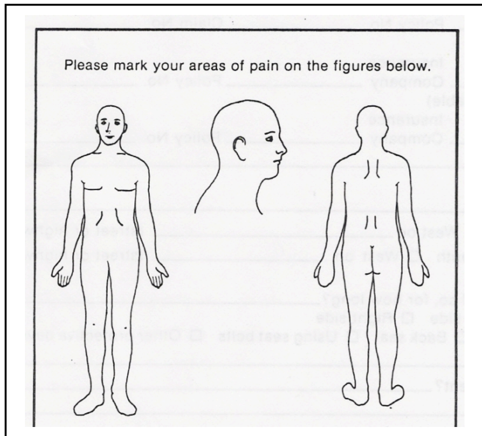
Since this injury are your symptoms _____ improving _____ getting worse _____ same?

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-INSTESTINAL 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

CARIO-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, 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 ____