Automobile Accident Questionnaire

Please answer all questions completely

Name_____ Marital Status____ Sex____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home ☎_____ Cell ☎_____ Email_____

Occupation_____ Employer _____ ☎_____
(Indicate if child, student, housewife, unemployed, retired)

Spouse's Name_____ Employer_____ ☎_____

Who referred you to our office?_____

What were the time and date of present injury? _____

Please explain in detail how your accident happened _____

_____

_____

_____

Do you carry medical coverage (MedPay) on your auto insurance? ☐ Yes ☐ No $_____

Name of your auto insurance carrier_____ Claim # _____

Name of adjuster handling claim_____ ☎_____

What health insurance coverage do you have? _____
(Please provide a copy of your insurance ID card)

Have you retained an attorney? ☐ Yes ☐ No If so, name, address, and ☎ of attorney: _____

_____

You were heading ☐ North ☐ East ☐ South ☐ West on (street or highway)_____

Other vehicle was heading ☐ North ☐ East ☐ South ☐ West on (street or highway) _____

Were police notified? ☐ Yes ☐ No Was an ambulance called? ☐ 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 ☐ Frontseat ☐ Backseat ☐ Usingseatbelts ☐ Otherprotectivedevices

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, Dr's name_____

Doctor's diagnosis_____ ☐ DC ☐ MD ☐ DO ☐ DDS

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?_____

ADDITIONAL HEALTH INFORMATION

Drugs you now take_____

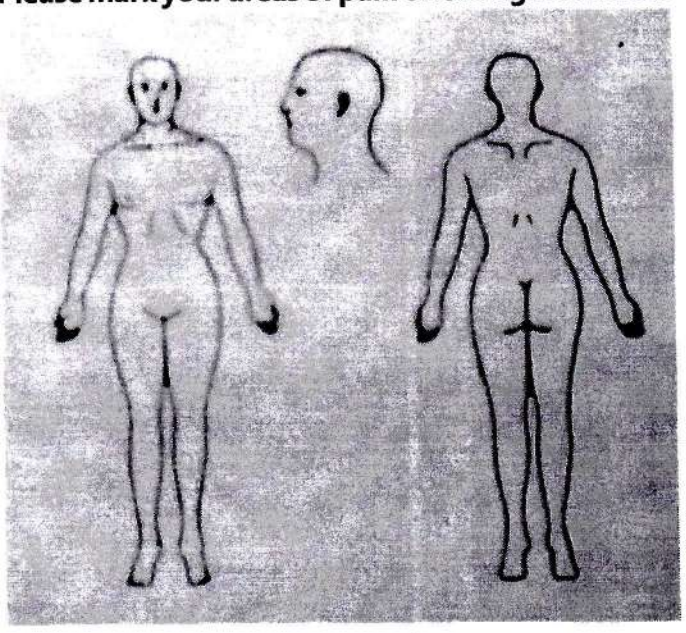
List surgical operations_____

Other health problems within your family?_____

Thank you for completing the above essential information

PLEASE TURN THIS FORM OVER, COMPLETE, AND SIGN WHERE INDICATED

Please mark your areas of pain on the figures below



Have You Ever Suffered From:

- ☐ Dizziness
- ☐ Fainting
- ☐ Blurred/Fading Vision
- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Colon Disorders
- ☐ Nervousness
- ☐ High Blood Pressure
- ☐ Fractures
- ☐ Polio
- ☐ Pneumonia
- ☐ TB
- ☐ Cancer
- ☐ Migraine
- ☐ Bone/Joint Disorders
- ☐ Rashes/Hives
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Meningitis
- ☐ Gall/Kidney Stones
- ☐ Anemia
- ☐ Other

INSURANCE INFORMATION

It is the patient's responsibility to file a claim with their insurance carrier, and submit necessary paperwork to the insurance company as requested. We will submit all claims directly to the insurer and await their payment; but, if your case is denied, you or your private medical insurance company may be fully or partially responsible for all expenses incurred.

I authorize this chiropractic office to release any information concerning my care, which is necessary for claims processing, to the appropriate insurance companies and/or attorneys that may be involved with my case.

Signature_____ Date_____