AUTOMOBILE ACCIDENT QUESTIONNAIRE

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. WOULD YOU PLEASE COMPLETE THE FOLLOWING:

Patient Information

Date: ______________________________

Name: ____ **Age:**______ **Date of Birth:** ________________

Give date and time present injury occurred ____/____/____ _______________ **AM PM**

Please explain in detail how your accident happened?

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Were you heading? North | South | East | West on___________________(street or highway)

Number of people in your vehicle_______ Were police notified? Yes | No

Did your head strike windshield or object? Yes | No

Were you knocked unconscious? Yes | No If so, for how long_____________________________

Were you? Driver | Passenger | Front seat | Back seat | Using seat belts | Other protective devices

Did you feel pain immediately after the accident? Yes | No | Later that day | Next day | Other: _______________

Where did you feel pain after the accident? Neck | Upper-Back | Mid-Back | Low Back | Other:______________

Where were you taken after the accident?____

Was treatment given? Yes | No If so what?____

Was any doctor consulted after the accident? Yes | No

If so, doctor's name____ D.C. | M.D. | D.O. | P.A.

Doctor's 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 the injury, are your symptoms Improving | Getting worse | the same

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CA_______DR_______

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