

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 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

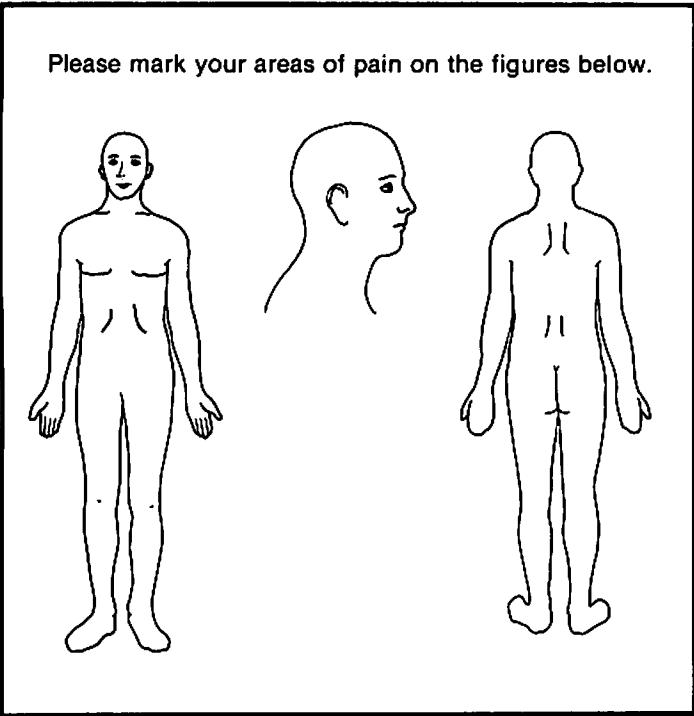
Are your work activities restricted as a result of this accident? Yes No

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.

- | | | | |
|---|--|---|--|
| <p>MUSCULO-SKELETAL SYSTEM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low back problems <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Neck problems <input type="checkbox"/> Arm problems <input type="checkbox"/> Leg problems <input type="checkbox"/> Swollen joints <input type="checkbox"/> Painful joints <input type="checkbox"/> Stiff joints <input type="checkbox"/> Sore muscles <input type="checkbox"/> Weak muscles <input type="checkbox"/> Walking problems <input type="checkbox"/> Ruptures <input type="checkbox"/> Broken bones | <p>GENITO-URINARY SYSTEM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder trouble <input type="checkbox"/> Excessive urination <input type="checkbox"/> Scanty urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Discolored urine <p style="text-align: center;">FEMALE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Vaginal pain <input type="checkbox"/> Breast pain <input type="checkbox"/> Lumps on breast <p>Are you pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>GASTRO-INTESTINAL SYSTEM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Difficult chewing <input type="checkbox"/> Difficult swallowing <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting food <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stool <input type="checkbox"/> Bloody stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Weight trouble <p style="text-align: center;">NERVOUS SYSTEM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Numbness <input type="checkbox"/> Loss of feeling <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Muscle jerking <input type="checkbox"/> Convulsions <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression | <p>CARDIO-VASCULAR-RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Pain over heart <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Coughing phlegm <input type="checkbox"/> Coughing blood <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Lung problems <input type="checkbox"/> Varicose Veins <p>EYE, EAR, NOSE, AND THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye strain <input type="checkbox"/> Eye inflammation <input type="checkbox"/> Vision problems <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear noises <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nose pain <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Nose discharge <input type="checkbox"/> Difficult breathing thru nose <input type="checkbox"/> Sore gums <input type="checkbox"/> Dental problems <input type="checkbox"/> Sore mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficult speech |
|---|--|---|--|



Patient's Signature

..... DO NOT WRITE BELOW THIS LINE

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