Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic 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 _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

List the extent of injuries as you know them: _____

Is there a possibility you are pregnant? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach Upset	☐ Light Bothers Eyes	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Fainting	☐ Sleeping Problems	☐ Loss of Balance	☐ Back Pain
☐ Face Flushed	☐ Pins and Needles in Legs	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in Fingers	☐ Loss of Smell	☐ Fever
☐ Irritability	☐ Numbness in Toes	☐ Loss of Taste	☐ Chest Pain
☐ Cold Sweats	☐ Shortness of Breath	☐ _____	☐ _____

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

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 treatment was given? _____

How often did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Have you ever been involved in an accident before? ☐ Yes ☐ No

If yes, please describe: _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete this question.

A. Last Day Worked: _____

B. Type of Employment: _____

C. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation you are receiving: _____

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?

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 adjuster _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his name and address _____

Number of people in your vehicle? _____ Other vehicle? _____

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

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

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

Were police notified? ☐ Yes ☐ No

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date _____

.....DO NOT WRITE BELOW THIS LINE.....

_____

_____

_____

_____

_____

Patient accepted? ☐ Yes ☐ No Doctor's Signature _____