

**IF YOU WERE THE DRIVER OF YOUR OWN VEHICLE, SOMEONE ELSE'S
VEHICLE OR A PASSANGER IN THE VEHICLE, ANSWER THIS SECTION
COMPLETELY.**

Your Auto Insurance Company
Name _____
Address _____
Policy # _____
Purchased from _____
Phone # _____

Your Health Insurance Company
Name _____
Address _____
Policy # _____
Purchased from _____
Phone # _____

Vehicle owner's name _____
Address _____
City _____ State _____ Zip _____

Vehicle owner's Auto Insurance Company
Address _____
City _____ State _____ Zip _____
Policy # _____
Purchased from _____
Phone # _____

Your driver's name _____
Address _____
City _____ State _____ Zip _____

Your driver's Auto Insurance Company
Name _____
Address _____
Policy # _____
Phone # _____

**IF ANOTHER VEHICLE WAS INVOLVED IN THE COLLISION, ANSWER THIS
SECTION COMPLETELY.**

Driver of other vehicle:
Name _____
Address _____
City _____ State _____ Zip _____

Other driver's Auto Insurance Company:
Name _____
Address _____
City _____ State _____ Zip _____
Policy # _____
Purchased From _____
Phone # _____

IF THE DRIVER WAS OPERATING SOMEONE ELSE'S VEHICLE:

Vehicle owner's name _____
Address _____
City _____ State _____ Zip _____

Vehicle owner's Auto Insurance Company
Name _____
Address _____
City _____ State _____ Zip _____
Policy # _____
Purchased from _____
Phone # _____

THE FOLLOWING INFORMATION IS REQUIRED OF ALL PATIENTS

Has this accident been reported to the police? _____ yes _____ no

If yes, did they come to the scene of the accident? _____ yes _____ no

If yes, did they cite anyone with a traffic violation? _____ yes _____ no

If yes, Whom? _____ myself _____ my driver _____ the other driver

Have you reported this accident to any insurance company? _____ yes _____ no.

If yes, Which one(s) _____ my own _____ my drivers _____ the owner of my drivers vehicle
_____ the other drivers _____ the owner of the other drivers vehicle

If a claim number has been assigned, please state _____
Claim #

Have you retained the services of an attorney? _____ yes _____ no.

If yes, Attorney's name _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Fax # _____

The information given in this questionnaire is true and accurate to the best of my knowledge.

Signed _____ Date _____

The staff of this chiropractic center appreciates your taking the time to gather this vital information. Please be assured we will do everything possible to assist you in your recovery. We will also make every effort to secure any coverage's that will enable you to receive whatever care you may need.

Thank you for your cooperation.

ACCIDENT HISTORY QUESTIONNAIRE

1. Date of accident: _____
2. Time: _____ AM / PM
3. Driver of car: _____
4. Where were you seated: _____
5. Who owns the car: _____
6. Year & Model of your car: _____
7. Year & Model of the other car: _____
8. What was the approximate damage done to your car? \$ _____
9. Visibility at time of accident: poor fair good other _____
10. Road conditions at time of accident: icy rainy wet clear dark other
(describe) _____
11. Where was your car struck:

FRONT

REAR

12. Type of accident: Head-on collision Broad-side collision Front impact Rear-end
 Non-collision
13. At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____
14. Did you see the accident coming? yes no
15. Did you brace for the impact? yes no
16. Were seatbelts worn? yes no
17. Were shoulder harnesses worn? yes no
18. Does your car have headrests? yes no
19. If yes, what was the position of the headrests compared to your head before the accident?
 Top of headrest even with bottom of head
 Top of headrest even with top of head
 Top of headrest even with middle of neck
20. Was your car breaking? yes no
21. Was your car moving at the time of the accident yes no
22. If yes, how fast would you estimate your speed? _____ mph
23. How fast would you estimate the other car was going? _____ mph
24. Head/body position at the time of impact:
 Head turned left / right Body straight in sitting position
 Head looking back Body rotated right / left
 Head straight forward Other: _____
25. As result of the accident were you Rendered unconscious In shock
 Dazed /Confused
 Other: _____

26. How was the shoulder harness adjusted? Loose Snug
27. Were you wearing a hat or glasses? Yes No
28. Could you move all parts of your body? Yes No
29. If no, what parts couldn't you move and why? _____

30. Were you able to get out of the car and walk unaided? Yes No
31. If no why not? _____
32. Did you get any bleeding cuts? Yes No if yes where? _____
33. Did you get any bruises? Yes No if yes where? _____
34. Please describe how you felt. _____
Immediately after the accident: _____
Later that day: _____
The next day: _____
35. Check symptoms apparent since the accident:
 Headache Neck pain Mid back pain
 Eyes light sensitive Pain behind eyes Dizziness
 Fainting Sleeping problems Numbness in fingers
 Numbness in toes Loss of smell Loss of taste
 Loss of Memory Fatigue Shortness of breath
 Irritability Depression Ringing / Buzzing
 Loss of balance Tension Cold hands
 Cold feet Diarrhea Constipation
 Chest pain Nervousness Cold sweats
 Anxious Low back pain Other: _____

36. Occupation: _____
37. Employer: _____
38. Have you missed time from work? Yes No
39. If yes, full time off work: _____ to _____
40. If yes, part time off work: _____ to _____
41. Did you seek medical help immediately after the accident? Yes No
42. If yes, how did you get there? Ambulance Police Drove own car Someone
else drove me Other _____
43. Doctor # 1 name _____
44. First visit date: _____
45. Were you examined: Yes No
46. Were x-rays taken? Yes No
47. Did you receive treatment? Yes No Medications Braces Collars
48. If yes, what kind of treatment did you receive? _____
49. What benefits did you receive from the treatment? _____
50. Date of last treatment? _____
51. Doctor # 2 name? _____

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52. First visit date: _____
53. Were you examined? Yes No
54. Were x-rays taken? Yes No
55. Did you receive treatment? Yes No
56. If yes, what kind of treatment did you receive? _____
57. What benefits did you receive from the treatment? _____
58. Date of last treatment? _____
59. Do you have an attorney on this claim? Yes No
60. If yes, who? _____
- Address: _____
- City: _____ State: _____ Zip: _____ Phone: _____

Illustrate below how the accident happened.

Past medical history: Place an (x) if it applies and describe.

- None related to current complaints Hospital or operation Auto accident
- Work accident Illness Other Describe: _____

SYSTEM REVIEW Place an (x) next to the symptoms you know you have.

Genito-Urinary System

- Bladder trouble Excessive urination Scanty urination
- Painful urination Discolored urine

Gastro-Intestinal System

- Poor appetite Excessive hunger Difficult chewing
- Difficult swallowing Excessive thirst Nausea
- Vomiting food Abdominal pain Diarrhea
- Constipation Black stool Bloody stool
- Hemorrhoids Liver trouble Gall bladder trouble
- Weight trouble

Nervous System

- | | | |
|---|--|--|
| <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 | |

Cardio-Vascular System

- | | | |
|---|--|--|
| <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"/> High blood pressure | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Lung problem | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Other |

Eye, Ear, Nose and Throat System

- | | | |
|--|---|--|
| <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"/> Breathing Difficulty | <input type="checkbox"/> Sore gums |
| <input type="checkbox"/> Sore mouth | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Speech difficulty | <input type="checkbox"/> Dental problems | |