AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because 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 accurate as possible while completing this form. Thank you.

Name: _____ **Date of Birth:** _____ **Soc. Sec. #:** _____
(First, Middle Initial, & Last)
Address: _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____ **Business Phone:** _____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed **Sex:** □ M □ F

Who referred you to our office? _____

Spouse's Information (if applicable):
Name: _____ Employer: _____ Location: _____
Soc. Sec. #: _____

Employment Information:
Occupation: _____ Business Phone: _____
(Indicate if child, student, housewife, unemployed, retired)
Employer/Company Name: _____ Location: _____

Accident/Insurance Information:
Please explain in detail how your accident happened:
_____
_____
_____

Insurance Co: _____ Policy No: _____ Claim No:_____
Driver of other vehicle (if any):
Name: _____ Insurance Co: _____ Policy No: _____
Driver of vehicle in which you were injured (if applicable):
Name: _____ Insurance Co: _____ Policy No: _____
Name of your Insurance Adjuster: _____
Have you retained an attorney? □ Yes □ No If so, her/his name & address:
_____
You were heading □ North □ East □ South □ West on _____ (street or highway)
Other vehicle (if applicable) 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? _____
Were you struck from □ Behind □ Front □ Left Side □ Right Side
Were you □ 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. □ Other
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?

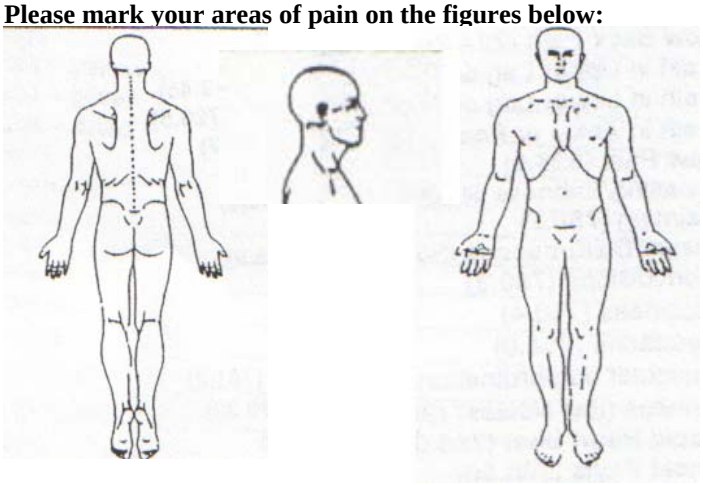
HEALTH QUESTIONNAIRE:
Please indicate for each of the questions below your experience by use of the following codes:
1 – never had, 2 – previously had, 3 – presently have

Musculo-Skeletal System
___ Low back problems
___ Pain between shoulders
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

Genito-Urinary System
___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE
___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast
Are you pregnant?
___ Yes ___ No

Please mark your areas of pain on the figures below:



Gastro-Intestinal System
___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black Stool
___ Bloody Stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM
___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

Cardio-Vascular Respiratory
___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Rapid heartbeat
___ Blood pressure prob.
___ Heart problems
___ Lung problems
___ Varicose Veins

EYE, EAR, NOSE, THROAT
___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Ear discharge
___ Hearing loss
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Diff. breath. thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

NOTES:

Patient accepted? Yes ___ No ___ Doctor's Signature: _____