Carriage House Chiropractic and Acupuncture

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Automobile Accident Questionnaire

Name:_____ Date:_____

1. Date of Accident: _____ Time:_____ a.m./p.m.
2. Driver of car: _____ Where you were seated:_____
3. Owner of car: _____ Year and Model of car:_____
4. Visibility at time of accident: poor/fair/good/other: _____
5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____
6. Where was your car struck? □ right □ left □ rear □ front □ side □ other: _____
7. Type of accident: □ head-on collision □ broad-side collision □ rear-end collision
   □ front impact, rear-ended car in front □ non-collision: _____
8. What part of the car was damaged? _____
9. Describe what happened to you upon impact? _____
10. Did you see the accident was about to happen? □ Yes □ No
11. Did you brace for impact? □ Yes □ No
12. Were you wearing a seatbelt? □ Yes □ No
13. Were you wearing a shoulder harness? □ Yes □ No
14. Does the car have headrests? □ Yes □ No
15. If yes, what was the position of your headrest? □ top of headrest even with bottom of head
    □ top of headrest even with top of head □ top of headrest even with middle of head
16. Was your car braking? □ Yes □ No Was the other car braking? □ Yes □ No
17. Was your car moving at the time of the accident? □ Yes □ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____
19. What was the position of your head and body at the time of impact?
    □ head turned left/right □ body straight in sitting position □ head looking back
    □ body rotated left/right □ head straight forward □ other: _____
20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: □ rendered unconscious □ dazed □ other: _____

22. Could you move all parts of your body? □ yes □ no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? □ yes □ no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? □ yes □ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that □ day □ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

□ headache	□ loss of smell	□ numbness in fingers	□ neck pain/stiffness
□ loss of taste	□ cold hands	□ mid-back pain	□ loss of memory
□ cold feet	□ low-back pain	□ fatigue	□ diarrhea
□ tension	□ constipation	□ pain behind eyes	□ shortness of breath
□ chest pain	□ dizziness	□ irritability	□ nervousness
□ fainting	□ depression	□ cold sweats	□ anxious
□ sleeping problems	□ loss of balance	□ numbness in toes	□ ringing/buzzing in ears
□ eyes sensitive to light	□ other:_____		

27. Have you missed time from work? □ yes □ no Work hours are: □ full-time □ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? □ yes □ no

29. Did you seek medical help immediately/soon after the accident? □ yes □ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? □ yes □ no If yes, of what body part? _____

32. What treatments have been provided? □ bed rest □ brace □ adjustments □ medications (list)_____

_____

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

35. Are any of your activities of daily living any different now compared to before the accident?

□ yes □ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Do you have an attorney handling this case? □ yes □ no

If yes, who? (name/address)_____

_____

Insurance Information

Patient's personal insurance: _____Insured's name: _____

Insurance Company Name: _____

Claim #: _____Adjuster's name/phone:_____

_____

Is there anything else in your life that has been affected by your injuries from the motor vehicle accident that we should know about?

_____

_____

Thank you for completing this form. The information you have provided will help us in attending to your healthcare needs.

I have read and completed all answers to the above questions to the best of my knowledge. I understand that failure to properly disclose all appropriate health history may hinder my health care provider's ability to properly diagnose and treat my complaints. I will, on all future visits, inform my health care provider of changes in my health status.

Your signature _____ Date _____

Provider's signature _____ Date _____