

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Patient \_\_\_\_\_ Date \_\_\_\_\_  
Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ No. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_  
Who referred you to our office? \_\_\_\_\_  
Social Sec. # \_\_\_\_\_ Business Phone \_\_\_\_\_ Company Name \_\_\_\_\_  
Company Address \_\_\_\_\_  
Please explain in detail how your accident happened? \_\_\_\_\_  
\_\_\_\_\_

Driver of other vehicle (if any) \_\_\_\_\_  
Name of person who has made contact with you \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Policy No. \_\_\_\_\_  
Claim No. \_\_\_\_\_  
Name of driver of vehicle in which you were injured (self or other) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Policy No. \_\_\_\_\_  
Claim No. \_\_\_\_\_

Name of person who has made contact with you \_\_\_\_\_  
Have you retained an attorney?  Yes  No  Not Yet  
If so, his/her name, address & phone # \_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_  
You were heading?  North  South  East  West on \_\_\_\_\_ (street or highway)  
Other vehicle was heading?  North  South  East  West on \_\_\_\_\_ (street or highway)

Number of people in vehicle \_\_\_\_\_  
Were police notified?  Yes  No Did head strike windshield or object?  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  
Did you feel pain immediately after the accident?  Yes  No  Later that day  Next day  When \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_  
Where were you taken after the accident? \_\_\_\_\_  
What treatment was given? \_\_\_\_\_

Was any doctor consulted after the accident?  Yes  No  
If so, give doctor's name \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S.  
Doctor's 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 the injury, are your symptoms  Improving?  Getting worse?  The same?

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

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

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

### ARE YOU PREGNANT?

- Yes     No

## GASTRO-INTESTINAL SYSTEM

- Poor Appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- 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
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse

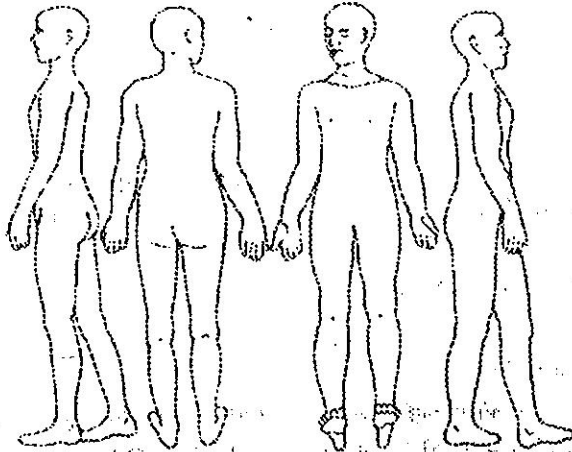
## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

### SYMPTOM LOCALIZATION



- P \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                     H \_\_\_ Hypoesthesia  
 S \_\_\_ Spasm

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, is for examination and x-rays only. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Guardian or Spouse's  
Signature of Authorizing Care \_\_\_\_\_

Date \_\_\_\_\_