
**HEALTH INFORMATION AND HEALTH HISTORY**

**AUTO ACCIDENT QUESTIONNAIRE**

Dear Patient: This information is considered confidential. 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 concise and accurate as possible while completing this form. Thank You.

Name_____ D.O.B._____
S.S.N.:_____
Address: _____City:_____State:_____
Zip: _____ Home Phone: _____

**AUTO INJURY**
Date of Accident: _____
Time of accident: _____

To your knowledge what caused the accident? _____
_____

_____

What occurred following the accident? Check all that apply

__Received emergency care __Felt confused __Felt nervous __Felt weak

__Loss of consciousness __Transported to the hospital via ambulance

After the accident you were taken to? _____

Position occupied in vehicle? __Driver __Front seat passenger __Back seat passenger

Were you wearing a seat belt? __Yes __No

How was your vehicle struck? __Front end __Rear end __Right side __Left side

Did the air bags deploy? __Yes __No

What speed were you traveling? _____What speed was the other vehicle traveling?___

What type of vehicle were you in? _____Type of other vehicle involved? _____

Was visibility? __Poor __Good

What was the condition of the roadway? __Wet __Dry Other:_____

Where did you feel pain immediately following the accident?_____

_____

Do you or did you have any visible abrasions? __Yes __No Where?_____
Have you lost any days of work? __Yes __ No If yes, _____through_____


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What type of treatment have you had since the accident? _____

_____

Are you taking medications due to injuries from this accident? __Yes __No If yes, what type? _____

Were x-rays or special tests performed following the accident? __Yes __No If yes, please list the name or facility where tests were performed: _____

_____

***CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT***

| | | | |
|---|---|---|---|
| ( ) Headache | ( ) Sleeping Problems | ( ) Lights Bother Eyes | ( ) Diarrhea |
| ( ) Neck Pain | ( ) Head Too Heavy | ( ) Loss of Memory | ( ) Feet Cold |
| ( ) Neck Stiff | ( ) Pins & Needles in Arms | ( ) Ears Ringing | ( ) Hands Cold |
| ( ) Dizziness | ( ) Pins & Needles in Legs | ( ) Face Flushed | ( ) Stomach Upset |
| ( ) Back Pain | ( ) Numbness in Fingers | ( ) Buzzing in Ears | ( ) Constipation |
| ( ) Nervousness | ( ) Numbness in Toes | ( ) Loss of Balance | ( ) Cold Sweats |
| ( ) Tension | ( ) Shortness of Breath | ( ) Fainting | ( ) Fever |
| ( ) Irritability | ( ) Fatigue | ( ) Loss of Smell | ( ) Other |
| ( ) Chest Pain | ( ) Depression | ( ) Loss of Taste | |

**INSURANCE INFORMATION**

Your Insurance Company: _____Phone: _____
Policy #:_____ Claim #:_____

Address: _____City:_____State:_____ Zip: _____

Have you been contacted by an Insurance Adjuster regarding this claim: __ Yes __ No
Name of Adjuster: _____
Company: _____ Phone: _____

Do you have an attorney that has advised you in this case? __ Yes __ No
If yes, your Attorney's Name: _____Phone:_____
Address: _____City:_____State:_____Zip:_____

***Signature:*** _____

Doctor's Notes: _____
_____
_____
_____