Synergy Chiropractic Accident/Injury Questionnaire

DATE:____/____/_____

NAME:_____DOB:____/_____/____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

Have you retained an attorney? YES NO

If yes, what is his/her name and address:_____

_____

DATE OF ACCIDENT:_____TIME OF ACCIDENT:_____AM/PM

CITY OF ACCIDENT:_____ LOCATION OF ACCIDENT:_____

VEHICLE YOU WERE IN:_____

(year) (make) (model)

Road/weather conditions at the time of accident:_____
Did the police come to the accident scene? YES NO
Was a police report taken? YES NO

PREVIOUS TREATMENT

Were you taken to the hospital? YES NO

If yes, which hospital?_____

How did you get to the hospital?_____

What X-rays/MRIs/CT scans were taken at the hospital?_____

What treatment was given?_____

Was any other doctor consulted after your accident? YES NO

If yes, what is the doctor's name?_____

What was the diagnosis?_____

How often did you see the doctor?_____

Are you currently under any other doctor's care? YES NO

If yes, what is the doctor's name?_____

ACCIDENT DETAILS

Where did you feel pain immediately after the accident?_____

_____

Were you knocked unconscious? YES NO

If yes, for how long?_____

You were struck from:

- o BEHIND
- o FRONT
- o LEFT SIDE
- o RIGHT SIDE

Were you wearing a seatbelt? YES NO

If yes, what kind?

- o A LAP BELT
- o A SHOULDER & LAP BELT

How far is the top of the headrest from the top of your head?

Approximately:_____inches: ABOVE BELOW

Were you the driver? YES NO

If no, as a passenger, where in the vehicle were you:

- o FRONT SEAT
- o BACK SEAT

Was your vehicle stopped at the time of impact? YES NO

If yes, was the driver's foot on the brake? YES NO

If the vehicle was moving at the time of impact, was it:

- o SLOWING DOWN
- o @ STEADY RATE OF SPEED
- o GAINING SPEED

Was your body pointed straight forward? YES NO

If no, what direction was it turned and by how much?_____

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

What happened immediately after the accident?

_____

_____

_____

Did you get any cuts/bruises during this accident? YES NO

If yes, where?_____

On what part of the vehicle did the following body parts hit?

Head_____ Chest_____

Right/Left Hip_____ Right/Left Arm_____

Right/Left Knee_____ Right/Left Leg_____

Right/Left Shoulder_____ Other_____

Did anything fly off of your face, the seat, or dashboard? YES NO

If yes, what was it and where did it land?_____

_____

What car parts broke during the accident?_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- Headache
- Neck pain
- Neck stiffness
- Dizziness
- Back pain
- Nervousness
- Tension
- Irritability
- Chest pain
- Sleeping problems
- Head too heavy
- Pins/needles in arms
- Pins/needles in legs
- Numbness in toes
- Shortness of breath
- Fatigue
- Depression
- Lights bother eyes
- Loss of memory
- Ears ringing
- Face flushed
- Buzzing in ears
- Loss of balance
- Fainting
- Loss of smell
- Loss of taste
- Diarrhea
- Feet cold
- Hands cold
- Stomach upset
- Constipation
- Cold sweats
- Fever
- Other

WORK RESTRICTIONS

Are your work activities restricted as a result of this accident? YES NO

Total work days missed:_____

If back to work describe any restrictions:_____

How has the injury from the accident affected your lifestyle?_____

_____

If you have been in previous auto accidents, please list the year of each:

_____ _____ _____

INSURANCE INFORMATION:

Insurance Company_____Phone_____

Claim Number:_____Ins. Adjustor's Name_____

Other Party's Name_____Phone_____

Other Party's Ins. Co_____Phone_____

Patient Signature:_____**Date**:_____