AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: *We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care 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 neat and accurate as possible while completing this form. Thank You.*

Name: _____ **Today's Date:** _____ **Sex:** M or F **Marital Status:** S M D W
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone#: ( ) _____ **Work Phone#:** ( ) _____
Date of Birth: _____ **Patient's Social Sec.#:** _____

Who Referred you to our office? _____

Occupation: _____ **Company Name:** _____
(indicate if child, student, housewife, unemployed, retired)

Spouse's Name: _____ **Spouse's S.S.#:** _____ **Spouse's Employer:** _____

Please explain in detail how your accident happened: _____
_____
_____
_____

Driver of Vehicle in which you were injured (if applicable):
Name: _____ **Relationship if not self:** _____

Name of your Auto Insurance: _____
Is this an HMO or PPO Plan? _____ **Name of PPO Insurance?** _____
Claim Number: _____ **Policy Number:** _____
Name of your insurance Adjustor: _____ Phone Number: _____
Name of your insurance Agent: _____ Phone Number: _____

Have you retained an attorney? ☐ Yes ☐ No If so, his name and address: _____
_____

Accident Information:

You were heading: ☐ North ☐South ☐East ☐West on _____ (Street or Highway)
Other Vehicle was heading: ☐North ☐South ☐East ☐West on _____ (Street or Highway)
Were Police Notified? ☐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
The date of the Accident: _____ **Time of Accident:** _____
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 your accident: ☐Yes ☐No
If so, what was the doctor's name? _____ ☐D.C., ☐M.D., ☐D.O., ☐D.D.S.
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; 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

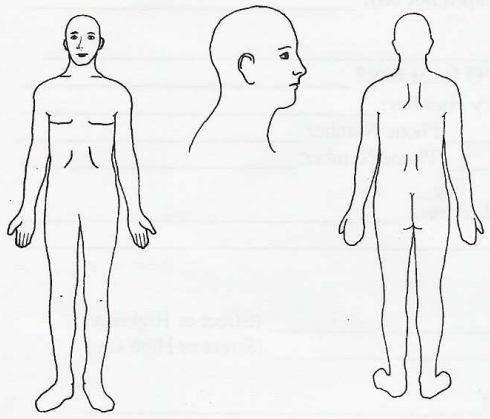
GENITO-URINARY SYSTEM

___Bladder trouble
___Excessive urination
___Scanty urination
___Painful urination
___Discolored urine

FEMALE

___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breasts
Are you pregnant?
☐Yes ☐No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___Excessive hunger
___Difficulty chewing
___Difficulty 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
___Foregetfulness
___Confusion
___Depression

CARDIO-VASCULAR RESPIRATORY

___Chest pain
___Pain over heart
___Difficulty breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid heartbeat
___Blood pressure problems
___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
___Sore gums
___Dental problems
___Sore mouth
___Sore throat
___Hoarseness
___Difficult speech
___Hard to breath thru nose

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 me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminated my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and 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/Guardian's Signature: X_____ **Date:** _____
Patient Accepted? Yes_____ No_____ **Doctor's Signature:** _____