AUTOMOBILE ACCIDENT QUESTIONNARE

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. Thank You

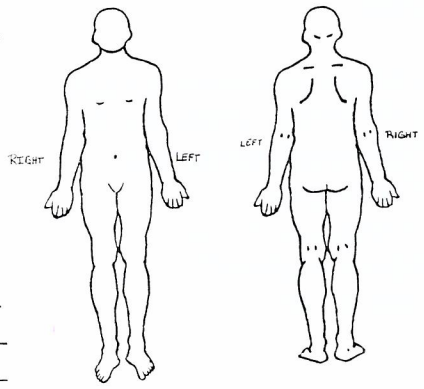
Name_____ Today's Date_____ Sex: M or F_____

Address_____City_____State_____Zip_____

Marital Status: S M D W Home Phone#_____Work Phone#_____

Date of Birth_____SS#_____Occupation_____Employer_____

ACCIDENT INFORMATION
Driver of Vehicle in which you were injured_____relationship_____
The Date of Accident_____Time of Accident_____
You were heading ( ) North ( ) South ( ) East ( ) West on _____(street or highway)
Other vehicle was heading ( ) North ( ) South ( ) East ( ) West on_____
You were struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right Side
You were: ( ) Driver ( ) Front Passenger ( ) Rear Passenger Seat Belts Used? ( ) Yes ( ) No
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 Doctor's Name_____
What was the diagnosis?_____
Have you had any complaints in the involved area before? ( ) Yes ( ) No
If so, what were the complaints_____
Are your work activities restricted as a result of this accident?_____
Since the injury are symptoms ( ) Improving ( ) Getting Worse ( ) Same



Please mark your areas of pain on the figures at right--→

Name of **Your** Auto Insurance_____policy#_____
Do you have Med Pay? ( ) Yes ( ) No if yes claim#_____
Name of Your Insurance Adjustor_____phone#_____
Name of Your Health Insurance_____

Name of the **Other Drivers** Auto Insurance_____policy#_____
Claim #_____Name of Insurance Adjustor_____Phone#_____
Have you retained an Attorney? ( ) Yes ( ) No
If so, name and address:_____
Please explain how your accident happened:_____
_____
_____
_____
_____
_____

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
( ) 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

( ) Abnormal vaginal discharge
( ) Abnormal vaginal bleeding
( ) Abnormal vaginal pain
( ) Breast pain
( ) Lumps on breasts

Are you pregnant?
( ) yes ( ) no

Gastro-Intestinal

( ) Poor appetite
( ) Excessive hunger
( ) Difficulty swallowing
( ) Difficulty chewing
( ) 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
( ) Confusion
( ) Depression

Eye, Ear, Nose & Throat

( ) Eye strain
( ) Eye inflammation
( ) Vision problems
( ) Ear pain
( ) Ear noises
( ) Ear discharge
( ) Hearing loss
( ) Nose pain
( ) Nose bleeding
( ) Sore gums
( ) Dental problems
( ) Sore mouth
( ) Sore throat
( ) Hoarseness
( ) Difficult speech
( ) Hard to breathe/nose

Cardio –Vascular Respiratory

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

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 upon receipt. However I clearly understand and agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine me and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authorization for these procedure to be performed. I also agree that I am responsible for all bills incurred in this office including any balance not paid by Health Insurance for the treatment of the auto accident related injuries. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian Signature_____ Date_____