



AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because 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 accurate as possible while completing this form. Thank you.

Name: _____

Date of Birth: _____

Date Of Accident: _____

Please Explain, in detail, how your accident happened:

Were police notified? Y / N Were you given an accident report or police report? Y / N

Were you knocked unconscious? y / N If so, for how long? _____

Were you struck from ___Behind ___Front ___Left Side ___Right Side

Were you ___Driver ___Passenger ___Front Seat ___Back Seat ___Using Seat Belt

Was there pain **immediately** after? Y / N If so, where? _____

Did you go to the hospital after that accident? Y / N

What treatment did they do at the hospital?

Was any other doctor consulted after your accident? Y / N

If so, what was the doctor's name and specialty? _____

Was treatment given? Y / N If so, what was done? _____

Are you still seeing that doctor and how often? _____

Have you ever had any complaints in the involved area before? Y / N

If so, what were the complaints? _____

Before the accident, were you capable of working on an equal basis with others your age? Y / N

Are your work activities restricted as a result of this accident? Y / N

Since the accident, are your symptoms ___Improving ___Getting Worse ___Same