Last Name: _____ First Name: _____Account #:_____

Automobile Accident Questionnaire

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and 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 neat and accurate as possible while completing this form. Thank You.

Name: _____ Sex: _____ Marital Status: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Who referred you to our clinic: _____

Social Security #: _____ Name of Insured: _____

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

Name of Insurance Adjustor: _____ Phone #:_____ Ext: _____

Driver of other vehicle (if any):_____ Their Insurance Company: _____

Date and Time of Accident: _____ Location of Accident: _____

Please explain in detail how your accident happened: _____

_____

_____

_____

Were you heading… North:__South:__East:__West:__Parked:__ on:_____Highway/Street/Road

Other vehicle was heading… North:__South:__East:__West:__Parked:__on:_____Highway/Street/Road

Were you struck from…Behind:__Front:__Left Side:__Right Side:__ and were Driver:__Passenger:__ in Front Seat:__Back Seat:__

Were you wearing a seatbelt: _____ Did the airbags deploy:_____ Front:_____ Side:____ Were the Police notified:_____

Were you knocked unconscious: _____ Were you taken to the Hospital/Doctor/ER: _____

Where did you feel pain immediately: _____ what treatment was given: _____

Have you consulted any other doctors for these conditions since the accident:_____ Name:_____

What treatment were you, and are you having for these conditions: _____

_____

Have you had any complaints in the involved area before: _____ when and what treatment: _____

Prior to the accident were you capable of working on an equal basis with others your age: _____

Have your work activities been restricted since the accident: _____ how: _____

Have you retained an attorney:_____ Their Name:_____ Phone:_____

Sign: _____ Date: _____ Parent or Guardian: _____