

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 #: XXX-XXXX-\_\_\_\_\_ 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 in the course of your employment at the time of the accident? \_\_\_\_\_

Were you a driver or a passenger in a Lyft, Uber, Taxi, Instacart or other "for hire" type vehicle? \_\_\_\_\_

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: \_\_\_\_\_