Automobile Accident Questionnaire

Accident Information

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ AM/PM

Driver of Automobile: _____ Where You Were Seated: _____

Owner of Automobile: _____ Year/Model of Automobile: _____

Visibility at time of accident: (circle one) Good / Fair / Poor / Other _____

Road conditions at time of accident: (circle one) Icy / Rainy / Wet / Clear / Dark / Other: _____

Where was the vehicle struck: (circle) Front / Rear / Side / Right / Left / Other: _____

Type of accident: (circle) Head-On / Broad-Side / Rear-End / Front Impact-Rear Ended Car In Front / Non-Collision / Other: _____

What part of the vehicle was damaged? _____

Describe what happened on impact: _____

_____

_____

Did you see that the accident was about to happen? (circle one) Yes / No

Did you brace for impact? (circle one) Yes / No

Were you wearing a seatbelt? (circle one) Yes / No

Were you wearing a shoulder harness? (circle one) Yes / No

Does the vehicle have headrests? (circle one) Yes / No

If yes, what was the position of the headrest at the time of impact? (check one)

- ☐ Top of headrest even with bottom of head
- ☐ Top of headrest even with top of head
- ☐ Top of headrest even with middle of head

Was your vehicle breaking? (circle one) Yes / No

Was the other car braking? (circle one) Yes / No

Was your vehicle moving at the time of the impact? (circle one) Yes / No

If yes, how fast do you estimate that you were moving? _____

How fast would you estimate that the other vehicle was moving? _____

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Automobile Accident Questionnaire

What was the position of your head and body at the time of impact? (check all appropriate)

- ☐ Head turned (right) / (left) - circle one
- ☐ Body straight in sitting position
- ☐ Head looking back
- ☐ Body rotated (right) / (left) - circle one
- ☐ Head straight forward
- ☐ Other: _____

At the time of the accident, recall what parts of your head or body hit the what parts of the vehicle:

_____

_____

_____

As a result of the accident, were you: (circle one)

Rendered unconscious / Dazed / Neither / Other: _____

Could you move all parts of your body? (circle one) Yes / No

If no, why not? _____

Were you able to get out of the car and walk unaided? (circle one) Yes / No

If no, why not? _____

Did you have any cuts or bruises from this accident? (circle one) Yes / No

If so, where? _____

Describe how you felt immediately after the accident: _____

_____

How did you feel later that day / night? _____

_____

How did you feel the next day (if accident wasn't today)? _____

_____

Check all symptoms experienced **since** the accident:

☐ Headache	☐ Loss of Smell	☐ Numbness in Fingers	☐ Neck pain / stiffness
☐ Loss of Taste	☐ Cold Hands	☐ Mid Back Pain	☐ Loss of Memory
☐ Cold Feet	☐ Low Back Pain	☐ Fatigue	☐ Diarrhea
☐ Tension	☐ Constipation	☐ Pain Behind Eyes	☐ Shortness of Breath
☐ Chest Pain	☐ Dizziness	☐ Irritability	☐ Nervousness
☐ Fainting	☐ Depression	☐ Cold Sweats	☐ Anxiety
☐ Sleeping Problems	☐ Loss of Balance	☐ Numbness In Toes	☐ Ringing / Buzzing In Ears
☐ Eyes Sensitive To Light		☐ Other: _____	

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Have you missed time from work / school? (circle one) Yes / No

If so, how much time have you missed? _____

Do you work? (circle one) Student / Work Part Time / Work Full Time / Unemployed / Other: _____

Did the accident occur during your work hours? (circle one) Yes / No

Did you seek medical help immediately / soon after the accident? (circle one) Yes / No

If yes, how did you get there? _____

Doctor / Hospital / Clinic seen: _____ Date: _____

What was done there? _____

Were X-Rays taken? (circle one) Yes (what body parts) _____ / No

What treatment / prescriptions were given? (check appropriate)

- ☐ Bed Rest - For how long? _____
- ☐ Brace - For which body parts? _____
- ☐ Adjustments - For which body areas? _____
- ☐ Medications - List Names/Dosages/Purposes _____

_____

_____

- ☐ Surgery - On which body parts? _____

_____

_____

What benefits did you receive from treatment? _____

Date of last treatment: _____

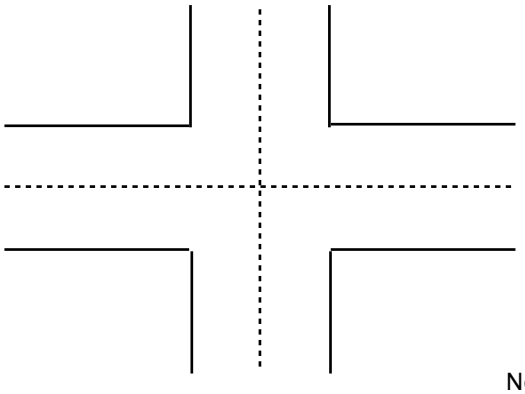
Are your activities of daily living any different now compared to before the accident? (circle one) Yes / No

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

Please indicate on the diagram below how the accident happened:



Comments: _____

_____

_____

_____

_____

_____

_____

_____

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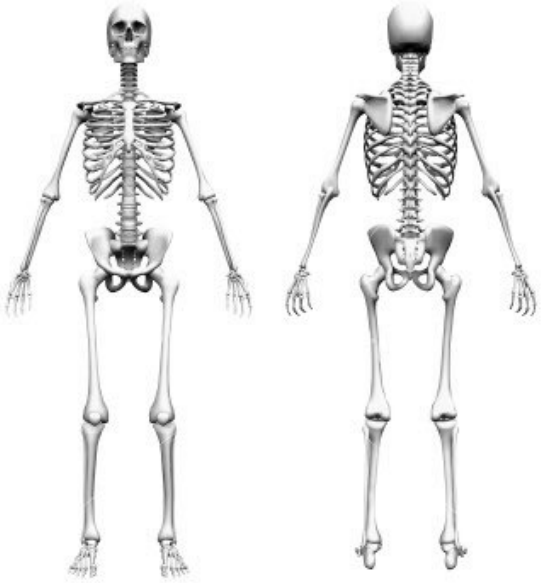
Do you have an attorney handling this case? (circle one) Yes / No

If so, whom: (name, address, telephone number) _____

_____

Pain Chart

Front **Back**



Please shade areas affected on this diagram, and label using the following abbreviations:

P=Pain
R=Radiation
N=Numbness

S=Soreness
A=Ache
St=Stiffness(ST)

Severity of symptoms: (Circle a number 0 - no pain through 10 - worst pain imaginable)

Headaches:	0	1	2	3	4	5	6	7	8	9	10
Dizziness:	0	1	2	3	4	5	6	7	8	9	10
Nausea:	0	1	2	3	4	5	6	7	8	9	10
Anxiety:	0	1	2	3	4	5	6	7	8	9	10
Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
Upper Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Pelvic Pain:	0	1	2	3	4	5	6	7	8	9	10
Tailbone Pain:	0	1	2	3	4	5	6	7	8	9	10
Chest Pain:	0	1	2	3	4	5	6	7	8	9	10
Abdominal Pain:	0	1	2	3	4	5	6	7	8	9	10
Genital Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Knee Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Ankle Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

Rt. Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Forearm Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Forearm Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Wrist Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Wrist Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Hand Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Hand Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Buttock Pain	0	1	2	3	4	5	6	7	8	9	10
Lt. Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Thigh Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Thigh Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Knee Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Ankle Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

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Insurance Information

Patient's automobile insurance carrier: _____

Insured's name (if other than patient): _____

Policy #: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ Zip: _____

Claim #: _____

Insurance Adjuster's Name/Phone: _____

Other party's insurance: _____

Insured's name (if other than patient): _____

Policy #: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ Zip: _____

Claim #: _____

Insurance Adjuster's Name/Phone: _____

Other insurance: _____

Insured's name (if other than patient): _____

Policy #: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ Zip: _____

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Claim #: _____

Insurance Adjuster's Name/Phone: _____

****** Please also fill out the Demographic Form (even if you have already been seen in the practice) *******

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Chiropractor On Wheels, LLC any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Chiropractor On Wheels, LLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Chiropractor On Wheels, LLC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses

Patient Signature: _____ Date: _____

Printed Name: _____

Printed Name and Signature of Parent/Guardian (if patient is a minor): _____
_____

Witness: _____

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