Arapahoe Chiropractic & Acupuncture Center
A Multidisciplinary Approach to Total Health Care

Motor Vehicle Accident Questionnaire

Name: _____ Date: ____/____/____ Phone: (____)-_____-_____

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

Date of Birth ____-____-_____

Employers Name: _____ Your Insurance Company:_____

Employers Address: _____ Policy # _____ Claim # _____

_____

Driver/Other Vehicle:_____ Have you retained an attorney? ( ) Yes ( ) No

Their Insurance Company:_____ Name of your attorney:_____

Policy # _____ Claim # _____ Attorney Phone: (____)-_____-_____

1. Date of Accident: ____/____/____ Time of Day: _____ ( )am ( )pm
2. Where did the accident occur:_____
3. Make/Model of your vehicle: _____ Other Vehicle(s):_____
4. Weather conditions:_____
5. Did the police file an accident report? ( ) Yes ( ) No
6. Did the police issue ticket(s)? ( ) Yes ( ) No To Whom:_____
7. What direction were you headed? () North ( ) East ( ) South ( ) West Street:_____
8. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West Street:_____
9. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
10. Did your car strike another: ( ) Vehicle ( ) Object/Other:_____ On what side: _____
11. At the time of impact was your car: ( ) Moving _____mph ( ) At a complete stop
12. Can you recall the estimated speed of impact: _____mph
13. What was the extent of damage to your vehicle (totaled/had to be towed):_____
14. What was the extent of damage to the other vehicle(s) (totaled/had to be towed):_____
15. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
16. Do you have any pictures of the accident? ( ) Yes ( ) No
17. Were you wearing a seatbelt? ( ) Yes ( ) No
18. At the time of impact, which way were you looking?

( ) Straight ahead ( ) Left ( ) Right ( ) Down

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19. Do you remember if you were knocked unconscious? ( ) Yes ( ) No If Yes, for how long?_____

20. Were there any witnesses? ( ) Yes ( ) No Name(s):_____

21. In your own words, please describe the accident:_____

_____

_____

_____

_____

22. After the accident, did you: ( ) Go home ( ) Go to work ( ) Go to the hospital

If you were taken to the hospital, how did you get there?_____

23. Name and location of hospital:_____

24. Were you seen in the emergency room? ( ) Yes ( ) No

Were you admitted to the hospital? ( ) Yes ( ) No

If admitted, how long did you stay? _____ Name of admitting physician:_____

25. Which of the following procedures were done at the hospital and to what region of the body:

Examination: _____ Stitches: _____ X-rays: _____

CAT scan: _____ MRI: _____ Therapy: _____

26. Were you given: ( ) Cervical collar ( ) Complete bedrest ( ) Medication(s):_____

27. Have you been treated by any other doctor since the accident? ( ) Yes ( ) No

If yes, Doctors name(s), specialties and phone number(s):_____

_____

28. In your own words please describe how you felt:

During the accident:_____

Immediately after the accident: _____

Later that day:_____

The next day:_____

29. What are your present complaints and symptoms: _____

_____

_____

30. Since this injury occurred are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

31. Do you recall if you struck any objects inside the car:

( ) Dashboard ( ) Headrest ( ) Windshield ( ) Airbag ( ) Steering column ( ) Rearview Mirror

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32. Can you recall any other details about the impact: ( ) Seat broke ( ) Glasses/hat flew off

( ) Other:_____

33. What portion of your body did you strike? ( ) Head ( ) Chest ( ) Face ( ) Knees ( ) Arms

( ) Other:_____

34. Do you recall if you were cut / bleeding or if there was any bruising? ( ) Yes ( ) No

If yes, where?_____

35. Did you have any physical complaints before the accident? ( ) Yes ( ) No

If yes, please describe in detail:_____

_____

36. Do you have any present or previous illnesses? ( ) Yes ( ) No

If yes, please describe in detail:_____

_____

37. Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including dates and types of accidents, as well as injuries received:

_____

_____

_____

38. Have you ever been treated for neck or back problems by any other physician prior to this accident?

( ) Yes ( ) No If yes, please describe in detail:_____

_____

39. Before the injury, were you able to work on an equal basis with others your age? ( ) Yes ( ) No

40. Are your work activities restricted as a result of this accident? ( ) Yes ( ) No

41. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, when was the last day you worked? ____/____/____

Type of employment: _____

42. Are you being compensated for time lost from work? ( ) Yes ( ) No

If yes, please state type of compensation your receiving:_____

43. Please list all medications you are taking: _____

_____