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1269 South Main Street
Wake Forest, NC 27587

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

AUTOMOBILE/ACCIDENT QUESTIONNAIRE

Patient Name: ____________________ **Date:** ____________________

VEHICLE YOU WERE IN

Vehicle type?
☐ Car ☐ Pickup ☐ Van ☐ Truck ☐ Station Wagon
☐ Bus ☐ Other ____________________

Vehicle size?
☐ Subcompact ☐ Full-Size ☐ Compact ☐ Mini
☐ Mid-Size ☐ Light ☐ Other __________

What was your location in the vehicle?
☐ Driver ☐ Front Passenger ☐ Rear Passenger
Passenger Location: ☐ Left ☐ Middle ☐ Right
☐ Other ____________________

What was the vehicle you were in doing?
Mark only one box for the above question
Vehicle stopped for ☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐Traffic ☐ Pedestrian ☐ Parked
☐ Other ____________________

Vehicle slowing down for☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Pedestrian ☐ Turning
☐ Parking ☐ Other ____________________

Vehicle moving ☐ Slowly ☐ Moderately ☐ Fast
☐ _______MPH ☐ Accelerating
☐ Other ____________________

What damage did the vehicle you were in sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other ____________________

IF OTHER VEHICLES INVOLVED IN ACCIDENT

First vehicle to strike vehicle you were in
Vehicle type? ☐ Car ☐ Pickup ☐ Van ☐ Truck
☐ Station Wagon ☐ Bus ☐ Other __________

Vehicle size? ☐ Subcompact ☐ Full-Size ☐ Compact
☐ Mini ☐ Mid-Size ☐ Light
☐ Other ____________________

How did this vehicle strike the vehicle you were in?
☐ Head On ☐ From Right ☐ From Left
☐ Rear Ended ☐ Sideswiped on Right
☐ Sideswiped on Left
☐ Other ____________________

What damage did this vehicle sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other ____________________

Second vehicle to strike the vehicle you were in
Vehicle type? ☐ Car ☐ Pickup ☐ Van ☐ Truck
☐ Station Wagon ☐ Bus ☐ Other __________

Vehicle size? ☐ Subcompact ☐ Full-Size ☐ Compact
☐ Mini ☐ Mid-Size ☐ Light
☐ Other ____________________

How did this vehicle strike the vehicle you were in?
☐ Head On ☐ From Right ☐ From Left
☐ Rear Ended ☐ Sideswiped on Right
☐ Sideswiped on Left
☐ Other ____________________

What damage did this vehicle sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other ____________________

Describe other vehicles to strike the vehicle you were in
☐ Vehicle Type: ____________________
☐ How it struck: ____________________
☐ Vehicle Size: ____________________
☐ Damage: ____________________

Were traffic citations issued as a result of the accident?
☐ No citations issued ☐ Driver of other vehicle
☐ Driver of vehicle you were in ☐ You
☐ Unsure

AT MOMENT OF IMPACT

Were you prepared for the accident?
☐ Accident was a complete surprise
☐ Aware of impending collision
☐ Braced for impact

Was your foot on the brake pedal at impact?
☐ Yes ☐ No

Were you wearing a restraint belt?
☐ Yes ☐ No

What type of restraint belt were you wearing?
☐ Shoulder-Lap Belt ☐ Shoulder Belt ☐ Lap Belt

Was your vehicle equipped with air bags?
☐Yes ☐ No ☐ Unsure

Did the airbags deploy?
☐ Yes ☐ No

What was your body position at impact?
☐ Straight ☐ Slouched Forward
ROTATED: ☐ Right ☐ Left ☐ Don't Recall
☐ Other ___________________________________

What direction was your body thrown?
☐ Forward/Backward ☐ Backward/Forward
☐ Sideways ☐ Outside Vehicle
☐ Under Vehicle ☐ Don't Recall
☐ Other ___________________________________

What position were your head/neck at impact?
☐ Straight ☐ Tilted Forward
ROTATED: ☐ Right ☐ Left ☐ Don't Recall
☐ Other ___________________________________

Through what motion were your head/neck pitched?
☐ Forward/Backward ☐ Backward/Forward
☐ Sideways ☐ Don't Recall
☐ Other ___________________________________

Where in items/people dislodged or displaced in your car at time of impact?
For example: Drink spilled/ejected, glasses thrown off, purse or other items in seat thrown to floor or items thrown out of dashboard/center console.

Please list and explain:
____
____
____
____
____
____
____
____

COVERAGE:

Did the Auto Accident occur while working on the job (Circle one)? YES NO

If yes, has the accident been filed as Worker's Compensation (Circle one)? YES NO Employer's Name: ___________________________________

Were the police notified (Circle one)? YES NO
Was a police report made (Circle one)? YES NO
Do you have a copy of the police report (Circle one)? YES NO **IF YES, PLEASE PROVIDE US WITH A COPY
Who was cited as the liable driver (the person responsible for the accident)?
____
Was Insurance Information exchanged (Circle one)? YES NO **IF YES, PLEASE PROVIDE US WITH A COPY

LIABILITY INFORMATION:
Has the accident been reported to the liability insurance company (Circle one)? YES NO
Insurance Carrier: ___________________________
Phone: ___________________________
Name of Adjuster: ___________________________
Name of Insured: ___________________________
Policy #: ___________________________
Claim #: ___________________________
Has the Liability Carrier paid for your vehicle damage (Circle one): YES NO

MEDPAY INFORMATION:
Has the accident been reported to your Auto Insurance Company (Circle one)? YES NO
Do you have medical payments coverage (MedPay) on your Auto Insurance plan (Circle one)? YES NO
Have you received any benefits from your Auto Insurance Company yet (Circle one)? YES NO
Insurance Carrier: ___________________________
Phone: ___________________________
Name of Adjuster: ___________________________
Name of Insured: ___________________________
Policy #: ___________________________
Claim #: ___________________________

ATTORNEY REPRESENTATION:
Have you retained an Attorney (Circle one)? YES NO
NAME: ___________________________
Phone: ___________________________

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ACCIDENT/INJURY QUESTIONNAIRE

Patient Name: ______________________________ **Date:**______________________

DATE AND TIME OF ACCIDENT/INJURY

Date: __/__/____ Time: _________am/pm

IMMEDIATELY AFTER ACCIDENT/INJURY

Did you lose consciousness?
☐ Yes ☐ No ☐ Don't Know

How did you feel?
☐ Confused ☐ Dazed ☐Dizzy ☐ Nervous
☐ Weak ☐ Other ________________________

Where did you immediately develop pain?
☐ Head ☐R ☐L Shoulder ☐R ☐L Buttocks
☐ Neck ☐R ☐L Arms ☐R ☐L Hips
☐Upper/Mid Back ☐R ☐L Elbows ☐R ☐L Thighs
☐Lower Back ☐R ☐L Forearms ☐R ☐L Knees
☐Pelvis ☐R ☐L Wrists ☐R ☐L Legs
☐ Chest/Rib Cage ☐R ☐L Hands ☐R ☐L Ankles
☐ Abdomen ☐R ☐L Feet
☐ Other ____

If there were cuts or bruising, where were they?
☐ Head ☐R ☐L Shoulder ☐R ☐L Buttocks
☐ Neck ☐R ☐L Arms ☐R ☐L Hips
☐Upper/Mid Back ☐R ☐L Elbows ☐R ☐L Thighs
☐Lower Back ☐R ☐L Forearms ☐R ☐L Knees
☐Pelvis ☐R ☐L Wrists ☐R ☐L Legs
☐ Chest/Rib Cage ☐R ☐L Hands ☐R ☐L Ankles
☐ Abdomen ☐R ☐L Feet
☐ Other ____

Emergency Care At Accident/Injury Site
Did you receive emergency care?
☐ Yes ☐ No

Destination After Accident/Injury
Where did you go?
☐ Hospital ☐ Home ☐ School ☐ Work
☐ Urgent Care ☐ Primary Care
☐ Other ____

By whom were you driven?
☐ Myself ☐ Ambulance ☐ Friend
☐ Family Member
☐ Other ____

HOSPITAL VISIT AFTER ACCIDENT/INJURY

What treatment was administered at the hospital?
☐ Oral Medication ☐ Sutures ☐ Splint
☐ Collar ☐ Injection ☐ Ice Packs
☐ Casts ☐ Support ☐ Bandages
☐ Hot Packs ☐ Brace ☐ Surgery
☐ Topical Antiseptics ☐ Other ________________________

Instructions Given When Discharged From Hospital
Were you told to see?
☐ General Practioner ☐ Chiropractor ☐ Neurologist
☐ Physical Therapist ☐ Orthopedist ☐ Internist
☐ General Surgeon ☐ Plastic Surgeon
☐ Other ____

What recommendations were made?
☐ No Further Care ☐ No Follow-Up Instructions
☐ Observation ☐ Rest ☐ Ice
☐ Heat ☐ Collar ☐ Support
☐ Time Off Work ☐ Other ________________________

Were medications prescribed?
☐ Pain ☐ Anti-Inflammatory ☐ Antibiotic
☐ Nervousness ☐ Other ______________________________

FOLLOWING THE ACCIDENT/INJURY

Since your accident/injury have you suffered from?
☐ Blurred Vision ☐ Chest Pain ☐ Nausea
☐ Double Vision ☐ Vomiting ☐ Difficulty Breathing
☐ Reduced Vision ☐ Palpitations ☐ Frequent Urination
☐ Impaired Hearing ☐ Constipation ☐ Inability to hold urine
☐ Ringing in Ears ☐ Diarrhea ☐ Painful Urination

Additionally have you experienced any of the following?
☐ Anxiety ☐ Convulsions ☐ Restlessness
☐ Depression ☐ Dizziness ☐ Insomnia
☐ Mood Swings ☐ Headaches ☐ Light Sensitivity
☐ Nervousness ☐ Fainting ☐ Reduced Appetite
☐ Poor Memory ☐ Tension ☐ Weakness
☐ Loss of Balance ☐ Fatigue ☐ Weight Gain
☐ Weight Loss
☐ Other ____

FOLLOWING THE ACCIDENT/INJURY

How much later did additional symptoms develop?

☐ Immediately ☐Hours ☐ That Evening
☐ Next Morning ☐ Days ☐ Week
☐ Month ☐ Other________________________

What additional symptoms developed?

Head
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Jaw
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Neck
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Upper/Middle Back
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Lower Back
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Pelvis
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Chest/Rib Cage
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Abdomen
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling
☐ Other ______________________________________

Shoulder
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Arms
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Elbows
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Forearms
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Wrists
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Hands/Fingers
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Buttocks
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Hips
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Thighs
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Knees
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Legs
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Ankles
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Feet/Toes
☐R ☐L Pain ☐R ☐L Stiffness ☐R ☐L Numbness
☐R ☐ L Tingling ☐ Other ________________________

Other ____

FOLLOWING THE ACCIDENT/INJURY

Are you restricted in any of the following areas as a result of this accident/injury?
☐ Daily Living ☐ Occupational/Work
☐ Recreational Activities ☐ Other ________________

Have you missed work due to this accident/injury?
☐ Missed No Work ☐ Limited Work Activity
☐ Missed Work From: ___/___/______ To ___/___/______
☐ Other ______________________________________

Did you self treat your symptoms?
☐Ice ☐ Heat ☐ Bed Rest
☐ Over-The-Counter Medication
☐ Other ______________________________________

Did you seek medical care elsewhere?
Medical Doctor Name:____________________________
Diagnosis and Treatment Recommendation:
____
____
____
____

Chiropractor (other than here) Name:_________________
Diagnosis and Treatment Recommendation:
____
____
____
____