ACCIDENT/INJURY QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU

PATIENT NAME: ______________________ **DATE:** ____________

DATE AND TIME OF ACCIDENT/INJURY

Date: ___/___/___ Time: ____________am/pm

DESCRIPTION OF ACCIDENT/INJURY

☐ Automobile Accident Questionnaire Marked (Skip this section)
☐ Workmen's Compensation Questionnaire Marked
☐ Slip/Fall Accident ☐ Pedestrian Accident
OTHER: ☐ Accident ☐ Injury ____________

What was the cause of your accident/injury?

____
____
____
____

Describe in your own words what happened:

____
____
____
____
____

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 Shoulders	☐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 lacerations (cuts), where were they?

☐ Head	☐R ☐L Shoulders	☐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 ____________

Describe any other significant injury:

____
____
____
____

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

What type of emergency care did you receive?
☐ Bandages ☐ Splints ☐ Brace ☐ Neck Collar
☐ Other ____________

Destination After Accident/Injury
Where did you go?
☐ Hospital ☐ Home ☐ School ☐ Work
☐ Other ____________

By Whom were you driven?
☐ Myself ☐ Ambulance ☐ Friend ☐ Family Member
☐ Other ____________

HOSPITAL VISIT AFTER ACCIDENT/INJURY

When did you go to the hospital?
☐ Immediately ☐ Later that day ☐ Next day ☐ Days later ☐
Date ____/____/____ ☐ Other ____________

☐ Hospital Name ____________

☐ Examined by Doctor ____________

Admitted : ☐ Yes ☐ No
☐ Date Discharged ____/____/____

If x-rays were taken, of what body part(s)?

☐ Head	☐R ☐L Shoulders	☐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 ____________

HOSPITAL VISIT AFTER ACCIDENT/INJURY

If a CAT Scan was performed, of what body part(s)?
☐ Head ☐ Upper/Mid Back ☐ Chest/Rib Cage
☐ Neck ☐ Lower Back ☐ Abdomen
☐ Other ______________________________

If a MRI was performed, of what body part(s)?
☐ Head ☐ Upper/Mid Back ☐ Chest/Rib Cage
☐ Neck ☐ Lower Back ☐ Abdomen
☐ Other ______________________________

What was the diagnosis given at the hospital?

Head
☐ Concussion ☐ Skull Fracture ☐ Lacerations
☐ Contusions ☐ Other ____________________

Jaw
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Whiplash ☐ Lacerations
☐ Contusions ☐ Other ____________________

Neck
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Whiplash ☐ Lacerations
☐ Contusions ☐ Disc Injury
☐ Other ______________________________

Upper/Middle Back
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Disc Injury ☐ Lacerations
☐ Contusions ☐ Other ____________________

Lower Back
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Disc Injury ☐ Lacerations
☐ Contusions ☐ Other ____________________

Pelvis
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Lacerations ☐ Contusions
☐ Other ______________________________

Chest/Rib Cage
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Lacerations ☐ Contusions
☐ Other ______________________________

Abdomen
☐ Strain ☐ Lacerations ☐ Contusions
☐ Other ______________________________

Shoulders
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Arms
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Elbows
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Forearms
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Wrists
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Hands/Fingers
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Buttocks
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Lacerations
☐R ☐L Other ______________________________

Hips
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Thighs
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Knees
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Legs
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Ankles
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Feet/Toes
☐R ☐L Strain ☐R ☐L Sprain ☐R ☐L Dislocation
☐R ☐L Fracture ☐R ☐L Lacerations ☐R ☐L Contusions
☐R ☐L Other ______________________________

Other
☐ Strain ☐ Sprain ☐ Dislocation
☐ Fracture ☐ Lacerations ☐ Contusions

Describe any additional diagnosis given:
____
____

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 Practitioner ☐ 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

How much later did additional symptoms develop?

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

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 ______

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

FOLLOWING THE ACCIDENT/INJURY

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 ____________________

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 Res
☐ Over-The-Counter Medication
☐ Other ____

Did you seek medical care elsewhere?

General Practitioner Name: ____________________
Diagnosis And Treatment Recommendation:

____
____
____

Internist Name: ______________________________
Diagnosis And Treatment Recommendation:

____
____
____

Chiropractor Name: ____________________________
Diagnosis And Treatment Recommendation:

____
____
____

Neurologist Name: _____________________________
Diagnosis And Treatment Recommendation:

____
____
____

Orthopedist Name: _____________________________
Diagnosis And Treatment Recommendation:

____
____
____

General Surgeon Name: __________________________
Diagnosis And Treatment Recommendation:

____
____
____

Plastic Surgeon Name: __________________________
Diagnosis And Treatment Recommendation:

____
____
____

Psychologist Name: ____________________________
Diagnosis And Treatment Recommendation:

____
____
____

Other Name: _________________________________
Type: _________________________________
Diagnosis And Treatment Recommendation:

____
____
____

Have you had any of the following tests?

☐ CT Scan ☐ MRI ☐ Electrodiagnositic Studies
☐ Other ____

What is the reason for seeking today's consultation?

☐ Persisting Complaints ☐ Worsening Of Symptoms
☐ Other ____

INSURANCE/ATTORNEY INFORMATION

Have you contacted an insurance adjuster or representative regarding this claim? ☐ Yes ☐ No

Company: ____________________________
Adjuster: ____________________________
Claim #: ____________________________

Have you engaged services of an attorney? ☐ Yes ☐ No

Attorney: ____________________________
Address: ____________________________
City: ____________ **State:** ______ **Zip:** ________
Phone: ____________________________

Have you filed an accident/injury report? ☐ Yes ☐ No

Have you filed for insurance benefits? ☐ Yes ☐ No

Parent's or Guardian Signature:

____

Date:

____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

CHIROPRACTIC PARTNERS

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU

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 ________________________

Vehicle doing other ☐ 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 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 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

CONDITIONS AT THE TIME OF ACCIDENT

What time of day did the accident occur?
☐ Daylight ☐ Dawn ☐ Dusk ☐ Night
☐ Other __________________________

What was the condition of the road?
☐ Dry ☐ Damp ☐ Wet ☐ Snow Covered
☐ Icy ☐ Other ____________________

What was the visibility at impact?
☐ Good ☐ Fair ☐ Poor
☐ Other __________________________

If visibility was poor, why?
☐ Sunlight ☐ Darkness ☐ Rain ☐ Snow
☐ Fog ☐ Traffic
☐ Other __________________________

AT MOMENT OF IMPACT

Were you prepared for the accident?
☐ Accident A Complete Surprise
☐ Aware Of Impending Collision ☐ And Braced For Impact

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

Was it knocked off pedal by 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 vehicle equipped with air bags?
☐ Yes ☐ No ☐ Unsure

Did the air bags 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
☐ Across Vehicle ☐ Outside Vehicle
☐ Under Vehicle ☐ Don't Recall
☐ Other ____________________

What position were your head/neck in 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 ____________________

Right upper extremity (arm)
☐Steering Wheel ☐ Dashboard ☐ Windshield
☐ Right Side Door ☐ Left Side Door ☐ Armrest
☐ Right Window ☐ Left Window ☐ Headrest
☐ Ceiling ☐ Console ☐ Shift Lever
☐ Front Seat ☐ Rear View Mirror
☐ Other ____________________

Left upper extremity (arm)
☐Steering Wheel ☐ Dashboard ☐ Windshield
☐ Right Side Door ☐ Left Side Door ☐ Armrest
☐ Right Window ☐ Left Window ☐ Headrest
☐ Ceiling ☐ Console ☐ Shift Lever
☐ Front Seat ☐ Rear View Mirror
☐ Other ____________________

Torso
☐Steering Wheel ☐ Dashboard ☐ Windshield
☐ Right Side Door ☐ Left Side Door ☐ Armrest
☐ Right Window ☐ Left Window ☐ Headrest
☐ Ceiling ☐ Console ☐ Shift Lever
☐ Front Seat ☐ Rear View Mirror
☐ Other ____________________

Right lower extremity (leg)
☐Steering Wheel ☐ Dashboard ☐ Windshield
☐ Right Side Door ☐ Left Side Door ☐ Armrest
☐ Right Window ☐ Left Window ☐ Headrest
☐ Ceiling ☐ Console ☐ Shift Lever
☐ Front Seat ☐ Rear View Mirror
☐ Other ____________________

Left Lower extremity (leg)
☐Steering Wheel ☐ Dashboard ☐ Windshield
☐ Right Side Door ☐ Left Side Door ☐ Armrest
☐ Right Window ☐ Left Window ☐ Headrest
☐ Ceiling ☐ Console ☐ Shift Lever
☐ Front Seat ☐ Rear View Mirror
☐ Other ____________________

Did your body strike any other objects?
Description Of Other Objects Your Body Hit:
____
____
____

RESULT OF IMPACT

Which objects in the vehicle did the force of the collision cause your body to strike?
HEAD
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Right Side Door ☐ Left Side Door ☐ Armrest
☐ Right Window ☐ Left Window ☐ Headrest
☐ Ceiling ☐ Console ☐ Shift Lever
☐ Front Seat ☐ Rear View Mirror
☐ Other ____________________

ADDITIONAL INFORMATION

Additional Information About Your Automobile Accident:
____
____
____
____

PATIENT'S OR GUARDIAN SIGNATURE:

____

DATE: ____________________