Renaissance Chiropractic Center

4902 Tacoma Mall Blvd. Tacoma, WA 9840 (253) 473-0300

Automobile Collision Questionnaire

Name: _____ Today's Date: _____ Date of accident: _____

Please Write A Detailed Description Of The Accident:

_____

_____

_____

_____

Is this incident work related ? _____

If auto accident, were you: [ ] driver [ ] passenger [ ] pedestrian

Location: City _____ State _____Street(s) _____

Road Conditions: [Dry] [Wet] [Icy] Other:_____

What kind of vehicle were you in:_____

What type of transmission in your vehicle: [ ] Automatic [ ] Manual (stick-shift)

Were you aware of the impending collision or were you surprised? [ ] Aware [ ] Surprised

If auto collision, were you struck from: [ ] behind [ ] right side [ ] left side [ ] front

Did the other car strike yours? [ ] yes [ ] no Did your car strike the others involved? [ ] yes [ ] no

Were there multiple impacts: [ ] yes [ ] no If yes, how many_____

Was your foot on the brake? [ ] yes [ ] no were you wearing your seatbelt? [ ] yes [ ] no

Did any Airbags deploy? [ ] yes [ ] no [ ] front [ ] side curtain

At the impact was your head facing: [ ] forward [ ] to the right [ ] to the left [ ] other:_____

How was the headrest positioned for your head? [ ] high [ ] low [ ] middle [ ] no head rest

After the collision, what direction was your vehicle facing: [ ] same [ ] to the right [ ] to the left

[ ] facing the opposite direction [ ] not sure [ ] other:_____

What was the other vehicle?_____

Was there more than one other vehicle involved: [ ] yes [ ] no how many?_____

What kind:_____

Did the impact cause you to lose your glasses or hat? [ ] yes [ ] no

Did you hit any part of the body on anything inside the vehicle? [ ] no [ ] yes, what?_____

Did you lose consciousness? [ ] yes [ ] no were you treated by the Paramedics at the scene? [ ] yes [ ] no

Were you taken by ambulance to the hospital emergency room? [ ] yes [ ] no

Did you have x-rays taken? [ ] yes [ ] no what regions?_____

Were you given any medications? [ ] yes [ ] no what?_____

Condition since Accident: [Worsened] [Improved] [Stayed the same]

PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headaches	[ ] Dizziness	[ ] Light Bothers Eyes	[ ] Diarrhea
[ ] Neck Pain	[ ] Head Seems Too Heavy	[ ] Loss of Memory	[ ] Constipation
[ ] Neck Stiffness	[ ] Pins and Needles in Arms	[ ] Ears Ringing	[ ] Stomach Upset
[ ] Upper Back Pain	[ ] Pins and Needles in Legs	[ ] Face Flushed	[ ] Hands Cold
[ ] Middle Back Pain	[ ] Numbness in Fingers	[ ] Buzzing in Ears	[ ] Feet Cold
[ ] Lower Back Pain	[ ] Numbness in Toes	[ ] Loss of Balance	[ ] Cold Sweats
[ ] Anxiety	[ ] Shortness of Breath	[ ] Loss of Smell	[ ] Fever
[ ] Irritability	[ ] Fatigue	[ ] Loss of Taste	[ ] _____
[ ] Chest Pain	[ ] Depression	[ ] Sleeping Problems	[ ] _____

Have you been involved in any prior motor vehicle collisions: [ ] Yes [ ] No

Patient's Auto Insurance: Do you have Personal Injury Protection (PIP) [ ] Yes [ ] No

Company Name: _____ Phone #: _____

Address: _____

Claim #: _____ Claim Manager's name: _____

Auto Insurance Company Responsible in Accident:

Company Name: _____ Phone #: _____

Address: _____

Name of person responsible for accident: _____

Name of insured on this policy: _____

Claim #: _____ Claim Manager's name: _____

General Health Insurance:

Ins Co: _____ Subscriber: _____ ID/Group #: _____

Do you have an attorney involved in this case? [ ] Yes [ ] No

If so, attorney's name: _____ Phone #: _____

I understand that interest will be charged on any unpaid balance due on my account commencing on the first day of my being released from active/scheduled treatment. Interest on my account shall be at the rate of twelve percent (12%) per annum on the balance owed by me and will be calculated half-yearly from date of my release from active/scheduled treatment and every six (6) months thereafter.

Patient's Signature: _____

Parent/Guardian's Signature: _____ **Date:** _____