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 _____

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

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 _____

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: _____

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

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:
_____
_____
_____
_____