VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last First Middle | Home Phone / E-Mail | DATE

ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | AGE | BIRTH DATE | SEX | MARITAL STATUS | NO. OF CHILDREN

EMPLOYER | ADDRESS | BUSINESS PHONE

OCCUPATION | WHO REFERRED YOU TO OUR OFFICE?

INSURANCE INFORMATION

YOUR INSURANCE COMPANY | POLICY NO. | CLAIM NO.

NAME OF OTHER VEHICLE'S DRIVER | OTHER VEHICLE'S INSURANCE COMPANY | POLICY NO.

NAME OF YOUR VEHICLE'S DRIVER | YOUR VEHICLE'S INSURANCE COMPANY | POLICY NO.

NAME OF YOUR INSURANCE ADJUSTER | PHONE

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:

DATE AND TIME OF ACCIDENT: ☐ A.M. ☐ P.M. | WERE POLICE NOTIFIED? ☐ Yes ☐ No

YOUR VEHICLE WAS HEADING:

☐ North ☐ South ☐ East ☐ West ON: ☐ Street ☐ Highway

OTHER VEHICLE WAS HEADING:

☐ North ☐ South ☐ East ☐ West ON: ☐ Street ☐ Highway

YOUR VEHICLE WAS STRUCK FROM THE: ☐ Front ☐ Back ☐ Driver's Side ☐ Passenger's Side | YOU WERE: ☐ Driver ☐ Front Seat ☐ Passenger ☐ Back Seat | WERE YOU USING A SEAT BELT? ☐ Yes ☐ No

WERE YOU UNCONSCIOUS? IF YES, HOW LONG? ☐ No ☐ Yes ► | WHERE WERE YOU TAKEN AFTER THE ACCIDENT?

EXACT AREA(S) OF PAIN IMMEDIATELY AFTER ACCIDENT:

WHAT TREATMENT WAS GIVEN?

WHAT DIAGNOSIS WAS GIVEN?

DOCTOR'S NAME: | HOW OFTEN DID YOU SEE THIS DOCTOR?

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS & PHONE:

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE ☐ No ☐ Yes ►

HAVE YOU RETAINED AN ATTORNEY? IF YES, GIVE NAME, ADDRESS & PHONE ☐ No ☐ Yes ►

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY? ☐ No ☐ Yes ►

BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE? ☐ Yes ☐ No | SINCE THIS INJURY, ARE YOUR SYMPTOMS: ☐ Improving ☐ The Same ☐ Getting Worse

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