AUTOMOBILE ACCIDENT QUESTIONNAIRE
PLEASE ANSWER ALL QUESTIONS COMPLETELY THEN CONSULT YOUR CHIROPRACTOR

Name_____ Date_____
Sex_____ Marital Status_____ Date of Birth_____ Home Phone #_____
Address_____ City_____ State_____ Zip_____
SSN_____ Work Phone #_____
Occupation_____ Employer_____
Who referred you to our office?_____
Please explain in detail how your accident happened (Please include date and time A.M./P.M.)_____
_____
Driver of the vehicle (if any)_____
Name of person who has made contact with you_____
Insurance Company_____ Address_____ Phone_____
Policy #_____ Claim #_____
Name of Driver of vehicle in which you were injured (self or other)_____
Insurance Company_____ Address_____ Phone_____
Policy #_____ Claim #_____
Have you retained an attorney? YES NO NOT YET
If so his/her name, address, phone #_____
You were heading? N S E W on_____(Street/Highway)
Other vehicle was heading? N S E W on_____(Street/Highway)
You were struck from? BEHIND FRONT LEFT SIDE FRONT RIDE SIDE FRONT LEFT SIDE BACK RIGHT SIDE BACK
Did any part of your body strike any part of the auto or another passenger? YES NO IF So where?
_____
Did you see the impact about to occur and have time to brace yourself or not? YES NO
Was your head turned right or left upon impact? RIGHT LEFT
Were there any lacerations, abrasions, contusions, fractures, or dislocations? YES NO If so where?_____
You were? DRIVER PASSENGER FRONT PASSENGER BACK
Seatbelts/harness/airbag used? YES NO
Number of people in the vehicle_____ Were the police notified? YES NO
Did head strike windshield or object? YES NO Were you knocked unconscious? YES NO
Did you feel pain immediately after the accident? YES NO LATER THAT DAY NEXT DAY
When_____
Where you taken to the hospital? YES NO If so, by ambulance or did someone drive you?_____
Were you examined, X-rayed, treated, or released?_____
If you were admitted, for how long?_____
Was any other doctor consulted after the accident? YES NO If so, give doctor's name_____
What did the doctors tell you regarding your injury?_____
Was medication administered? YES NO If so, which ones and for how long?_____
How often did you see the doctor?(weekly, monthly)_____
How long did you see the doctor?_____
Before the injury, were you capable of working on an equal basis with others your age? YES NO
Are your work activities restricted as a result of this accident? YES NO is so, how?_____
Since the injury, are your symptoms: IMPROVING? GETTING WORSE? THE SAME?

This information is being brought to you as a public service by
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