

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

## BROOKSVILLE CHIROPRACTIC INC.

*Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Chart # \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ A.M./P.M.

Patient's auto insurance carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

\*Please **circle** the correct statement below.

Were you the: driver , passenger , pedestrian , other \_\_\_\_\_

If you were NOT the driver, Name of the driver of the vehicle in which you were injured \_\_\_\_\_

Insurance company of driver \_\_\_\_\_ Policy # \_\_\_\_\_

At the time of impact you were: parked , moving , stopped at traffic light/stop sign , other \_\_\_\_\_

Street that accident occurred \_\_\_\_\_ Nearest cross street \_\_\_\_\_

City and State that the accident occurred \_\_\_\_\_

Direction your vehicle was heading: North , South , East , West

Direction other vehicle involved in accident was heading: North , South , East , West

What was your vehicle point of impact? Rear , Front , Driver's side , Passenger's side , other \_\_\_\_\_

Did your vehicle strike another vehicle? YES , NO

Your location in the vehicle: Front seat , Back seat , Third row , other \_\_\_\_\_

Were you using your seat belt? YES , NO

Were the police notified and a report filed? YES , NO

As a result of the accident, were traffic citations issued to you? YES , NO

To the driver of the other vehicle YES , NO . Or the driver of the vehicle in which you were injured YES , NO

Were you knocked unconscious? YES , NO If so, for how long? \_\_\_\_\_

Did airbags deploy? YES , NO

Where did you feel pain IMMEDIATELY following the accident? \_\_\_\_\_

Did you receive care at the accident scene? YES , NO

Where were you taken following the accident? \_\_\_\_\_

How did you get there? Ambulance , Car

What treatment was given (x-rays, CT scan, MRI, medication)? \_\_\_\_\_

Was any other physician consulted since the time of the accident? YES , NO

If so, what was the doctor's name: \_\_\_\_\_

What was your diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see this doctor? \_\_\_\_\_

Have you EVER had ANY previous trauma (motor vehicle accidents, work injury...)? YES , NO

If so, please describe (when, did you receive treatment...) \_\_\_\_\_

Have you EVER had complaints in the currently involved areas? YES , NO

If so, please describe \_\_\_\_\_



