PATIENT NAME: _____ DOB: _____ DATE: _____

CHIROPRACTIC CLINIC-WEST

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Accident date: _____ Accident time: _____ AM or PM

Were you the: ❑ driver ❑ front passenger ❑ rear passenger

Number of people in accident vehicle? _____

Did the police come to accident site? ❑ Yes ❑ No
Was a police report filed? ❑ Yes ❑ No
Were you wearing your seatbelt? ❑ Yes ❑ No
Was this vehicle equipped with airbags? ❑ Yes ❑ No
If yes, did it/they inflate? ❑ Yes ❑ No
Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe: _____
_____
_____

Make & Model of the vehicle you were occupying? _____

What was the approximate speed of your vehicle? _____MPH
Did the impact to your vehicle come from the: ❑ Front ❑ Rear ❑ Right side ❑ Left side ❑ Other
During impact, were you facing: ❑ Right ❑ Left ❑ Forward ❑ Backward
Were you ❑ aware or ❑ surprised by the impact?
If accident vehicle made impact with another vehicle...
Make & Model of that other vehicle? _____
Speed of other vehicle: _____MPH

In your own words, please briefly describe the accident: _____
_____
_____

Did the accident render you unconscious? ❑ Yes ❑ No If yes, how long? _____
Please describe how you felt immediately after the accident: _____
_____

Have you gone to a hospital or seen any other doctor? ❑ Yes ❑ No
When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus
How did you get there? ❑ Ambulance or ❑ Private transportation Was he/she a: ❑ DC ❑ MD ❑ DO
Describe any treatment you received: _____
Were x-rays taken: ❑ Yes ❑ No
Was medication prescribed: ❑ Yes ❑ No
Have you been able to work since this injury? ❑ Yes ❑ No
Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

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PAGE TWO

Indicate ☑ the symptoms that are a result of the accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problem	❑ Nausea	❑ Memory Loss
❑ Irritability	❑ Arms/Shoulders	❑ Back Pain	❑ Headaches	❑ Fatigues
❑ Numb hand/fingers	❑ Lower back pain	❑ Blurred vision	❑ tension	❑ chest pain
❑ back stiffness	❑ buzzing in ear	❑ neck pain	❑ shortness of breath	
❑ leg pain	❑ ears ringing	❑ neck stiffness	❑ stomach upset	
❑ numb feet/toes	❑ other: _____			

Is your condition getting worse? ❑Yes ❑No ❑Constant ❑Comes & Goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable Even if only sometimes	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

PLEASE SIGN HERE :_____ DATE: _____