FAMILY CHIROPRACTIC

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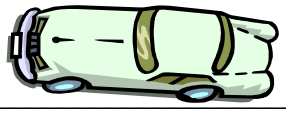
Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

NAME_____***DATE***_____

1. Date of Accident_____ 2. Time_____AM/PM
3. Driver of Car_____
4. Where were you seated?_____
5. Who owns the car?_____
6. Year & Model of your car_____
   Year & Model of the other car_____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident?
   POOR FAIR GOOD OTHER
9. Road conditions at the time of the accident:
   ICY RAINY WET CLEAR DARK
   OTHER (describe)_____
10. Where was your car struck? _____
    Please draw on this car where you were struck:
    In your own words, please describe the accident:



    _____
    _____
    _____
    _____
11. Type of Accident: Head On Collision Broad Side Collision
    Front Impact Rear-End Car in Front
    Rear Impact Non-Collision
12. At the time of the accident, recall what parts of our head or body hit what parts
    On the inside of your car:_____
13. Did you see the accident coming? Yes No
14. Did you brace for impact? Yes No
15. Were seatbelts worn? Yes No
16. Were shoulder harnesses worn? Yes No
17. Does your car have headrests? Yes No
18. If yes, what was the position of those headrests compared to your head
    before the accident? Top of Headrest even with **Bottom** of Head
    Top of Headrest even with **Top** of Head
    Top of Headrest even with **Middle** of Neck
19. Was your car braking? Yes No
20. Was your car moving at the time of the accident? Yes No
21. If yes, how fast would you estimate you were going? _____MPH
22. How fast would you estimate the other car was going? _____MPH

23. Head/Body position at the time of impact:
- ☐ Head turned left/right
- ☐ Head looking back
- ☐ Head straight forward
- ☐ Body straight in sitting position
- ☐ Body rotated right/left
- ☐ Other

24. As a result of the accident were you: ☐ Rendered Unconscious ☐ In Shock ☐ Dazed, circumstances vague ☐ Other

25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or sunglasses? ☐ Yes ☐ No
27. Could you move all parts of your body? ☐ Yes ☐ No
28. If no, what parts couldn't you move and why?_____

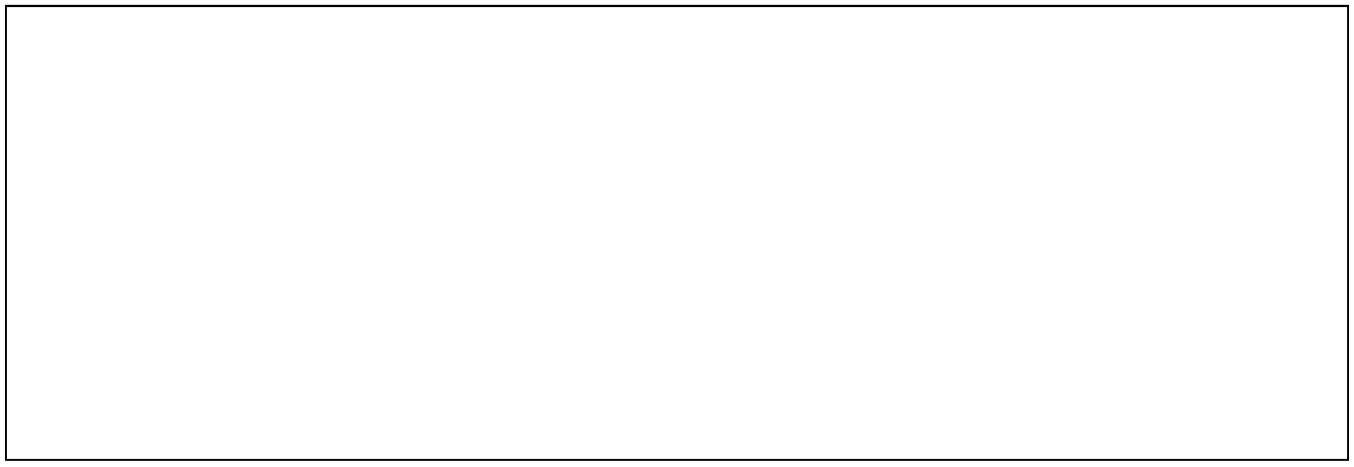
29. Were you able to get out of the car and walk unaided? Yes ☐ No ☐
30. If no, why not? _____
31. Did you get any bleeding cuts? Yes ☐ No ☐
32. Did you get any bruises? Yes ☐ No ☐
33. Please describe how you felt:
Immediately After the Accident:_____
Later that day:_____
The next day: _____

34. Check Symptoms apparent since the accident:

☐ Headache	☐ Chest Pain	☐ Pain Behind Eyes
☐ Eyes Light Sensitive	☐ Neck Pain/Stiffness	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in fingers
☐ Numbness in toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Anxious	☐ Nervousness	☐ Cold Sweats
☐ Low Back Pain	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Mid-Back Pain	☐ Other_____	

35.Occupation:_____
36.Employer:_____
37.Have you missed time from work? Yes No
38.If yes, full time off work_____to_____
39.If yes, part time off work_____to_____
40.Did you seek medical help immediately after the accident? Yes No
41.If yes, How did you get there? Ambulance Police Drove own car
Someone else drove me Other
42.Doctor #1: Name_____
43.First Visit Date:_____
44.Were you examined? _____
45.Were X-Rays Taken? Yes No
46. Did you Receive Treatment? Yes No
47. If yes, what kind of treatment did you receive? _____
48.What benefits did you receive from the treatment? _____
49.Date of last Treatment? _____
50. Doctor #2: Name: _____
51.First Visit Date: _____
52. Were you examined? Yes No
53.Were X-Rays Taken? Yes No
54.Did you Receive Treatment? Yes No
55.If yes, what kind of treatment did you receive? _____
56.What Benefits did you receive from the treatment? _____
57.Date of last treatment: _____
58.Do you have an attorney on this claim? Yes No
59.If yes, Who? _____
Address_____
City_____State_____Zip _____Phone_____

Illustrate below how the accident happened:



60. Past Medical History: Place an (X) if it applies and describe:

☐ None related to current complaints ☐ Hospital or Operation

☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other

Describe: _____

_____

_____

_____

61. Family History: Place an (X) if any family member has suffered from:

☐Tuberculosis	☐Epilepsy	☐Diabetes
☐Mental Illness	☐Allergy	☐Arthritis
☐Gout	☐Cancer	☐Migraines
☐Hypertension	☐Heart Attack	☐Other, list:
☐Kidney Disease	☐Spinal Disorder	_____

62. Personal History: Place an (X) if it applies, describe:

☐Single ☐Married ☐Divorced ☐Separated ☐Widow/Widower

63. Number of Children: _____ Number of Children at Home_____

64. Employed Spouse ☐ Yes ☐ No

65. Are you Pregnant? ☐ Yes ☐ No

66. Medications, describe:

_____

_____

67. Disease, describe:

_____

_____

68. Other, describe:

_____

_____