AUTOMOBILE ACCIDENT QUESTIONNAIRE

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 what kind of care you will need. If we do not sincerely believe your condition will respond to chiropractic care, we will refer you for outside care accordingly. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you from Doctor and staff.

Date _____ Name _____

Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

Social Sec. # _____-_____-_____ Bus. Phone (___)_____-_____ Company Name _____

Spouses Name _____ Spouse's SS # _____-_____-_____ Employer _____

E-mail address:_____ (to receive health information from our office)

Please explain in detail how your accident happened _____

_____

_____

_____

Were you heading North South East West on _____ (street or hwy)

Other vehicle was headed North South East West on _____ (street or hwy)

Have you retained an attorney? *Yes* *No* Litigation? *Yes* *No* *Maybe*

If so, name and address _____

Give time and date present injury occurred _____ AM PM _____ 20_____

Where did you feel pain immediately after the accident? _____

Did you return to work? *Yes* *No* If so, date returned to work _____

Did you consult any other doctor? *Yes* *No* If so, doctor's name _____

What treatments did you receive? _____

Have you ever injured this area before? *Yes* *No* If so when? _____

If injured before did you lose time from work? *Yes* *No*

If you lost time from work with injuries prior to this injury give name of doctor or doctors consulted _____

_____

Do any other diseases or accidents affect your employment? *Yes* *No* If so, explain _____

_____

Are your work activities restricted as a result of this accident? *Yes* *No*

Since this injury are your symptoms *improving?* *getting worse?* *the same?*

Have you ever had an Automobile Accident claim before? *Yes* *No* If so, when? _____

SPECIFICS ABOUT YOUR ACCIDENT:

What was your position in the vehicle? Driver's seat Front Passenger Rear Passenger Pedestrian

What type of vehicle were you driving ? _____

What speed were you traveling at the time of the accident? _____

Who hit who? Was struck by another vehicle Struck another vehicle Struck a stationary object

What was your vehicles point of impact? _____

What speed was the other vehicle traveling at the time of the accident? _____

What was the other vehicle's point of impact? _____

Were you wearing seat restraint's? Yes No

What position were your vehicle head rests in? Lowest Middle Highest Did your vehicle air bags deploy? Yes No

Where you prepared for the impact? was completely surprised by the accident saw the collision coming saw the collision coming and braced appropriately

What position was your body in just prior to impact? _____

What happened to your body at impact? _____

What was your emotional state after the accident? _____

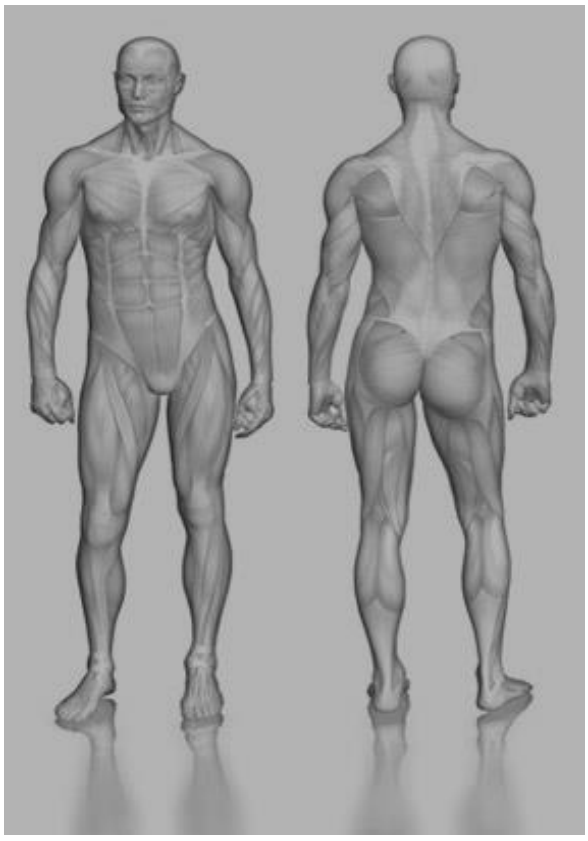
Did you receive medical attention at the scene of the accident? If so, what? _____

Where did you go immediately after the accident? (i.e. ER, doctor, home, work, etc.) _____

Did you hit any other body parts on parts of the vehicle at impact? If so, which? _____

_____

Please indicate the areas of pain with X's and areas of numbness or tingling with O's



HEALTH QUESTIONNAIRE:

Height: _____

Weight: _____

When was your blood pressure last taken?

_____

What was your blood pressure?

_____

Do you have a family history of High Blood Pressure? *YES NO*

Please indicate for by use of the following codes:

1-never had

2-previously had

3-presently have

MUSCULO-SKELETAL SYSTEM

____ Low back problems

____ Pain between shoulders

____ Neck problems ____ Arm problems ____ Leg problems ____ Swollen joints ____ Painful joints ____ Stiff joints ____ Sore muscles ____ Weak muscles ____ Walking problems ____ Ruptures ____ Broken Bones

GENITO-URINARY SYSTEM

____ Bladder trouble

____ Excessive urination

____ Scanty urination

____ Painful urination

____ Discolored urine

FEMALE

____ Vaginal discharge

____ Vaginal bleeding

____ Vaginal pain

____ Breast pain

____ Lumps in breast

Are you pregnant?

____ Yes ____ No

GASTRO-INTESTINAL SYSTEM

____ Poor appetite

____ Excessive hunger

____ Difficult chewing

____ Difficult swallowing

____ Excessive thirst

____ Nausea

____ Vomiting food

____ Vomiting blood

____ Abdominal pain

____ Diarrhea

____ Constipation

____ Black stool

____ Bloody stool

____ Hemorrhoids

____ Liver trouble

____ Gall bladder problems

____ Weight trouble

NERVOUS SYSTEM

____ Numbness

____ Loss of feeling

____ Paralysis

____ Dizziness

____ Fainting

____ Headaches

____ Muscle jerking

____ Convulsions

____ Forgetfulness

____ Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

____ Chest pain

____ Pain over heart

____ Difficulty breathing

____ Persistent cough

____ Coughing phlegm

____ Rapid heartbeat

____ Blood pressure problems

____ Heart problems

____ Lung problems

____ Varicose veins

EYE, EAR, NOSE, AND THROAT

____ Eye strain

____ Eye inflammation

____ Vision problems

____ Ear pain or noises

____ Hearing loss

____ Ear discharge

____ Nose pain

____ Nose bleeding

____ Difficult breathing thru nose

____ Dental problems

____ Popping noise in jaw

____ Sore mouth

____ Sore throat

____ Difficulty swallowing

____ Difficult speech

AUTOMOBILE INSURANCE INFORMATION

Name of policy holder _____

Insurance Co._____ Phone # _____

Address_____ City_____ State _____ Zip _____

Date of Injury _____ Policy No. _____ Claim No. _____

Name of Adjustor _____

ADDITIONAL INSURANCE (Secondary Insurance)

YesNo If Yes Complete the following:

Name of insured _____ Relationship to Patient _____

Birth date_____ Insurance Co._____ Phone # _____

Group # _____ Employer #_____

Insurance Co. Address_____ City_____ State____ Zip _____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____