Auto Accident Questionnaire

Date _____ Title: Mr. Mrs. Miss Ms. Dr. (circle one)
Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
E-mail Address _____
Social Security # _____ Age _____ Date of Birth _____ Sex: Male or Female
Height _____ Weight _____ Status: Married Single Widowed Divorced # of Children _____
Your Occupation _____ Employer _____
Employers Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Occupation _____ Employer _____
Nearest Relative Not Living with You _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Person Responsible For This Account _____
How were you referred to this office? Friend/Relative, Name _____
Yellow Pages Newspaper TV Direct Mail Exam Card
Coupon Radio Courtesy Call Other _____
Have you seen a Chiropractor in the Past? Yes No Name _____

Date of Accident: _____ Hour _____ a.m. p.m.
Location of Accident _____
Were you the: Driver Passenger Pedestrian
Were you struck from: Behind Front Left side Right side Vehicle was parked
Did your vehicle strike the other(s) involved? Yes No Did the other car(s) strike yours? Yes No
As a result of the accident, was there any traffic citation issued? Yes No
If yes, to whom? _____
Did you brace yourself before the impact? Yes No
Were you wearing a seatbelt? Yes No Did you feel the seat belt catch upon impact? Yes No
Was anyone else in the vehicle with you? Yes No
What care have they received? _____
Does your vehicle have airbags? Yes No If yes, did they deploy? Yes No
List the extent of your injuries as you know them: _____
_____
_____
Did you require post-accident hospitalization? Yes No
If so, where were you taken? _____
Were you disabled? Yes No If so, for how long? _____
Where did you feel pain immediately after the accident? _____

Check the symptoms you have noticed since the accident:

___ Headaches	___ Pins & Needles in Legs	___ Fatigue	___ Face Flushed
___ Neck Pain	___ Pins & Needles in Arms	___ Loss of Smell	___ Neck Stiff
___ Sleeping Problems	___ Numbness in Fingers	___ Loss of Taste	___ Ringing in Ears
___ Back Pain	___ Numbness in Toes	___ Diarrhea	___ Buzzing in Ears
___ Nervousness	___ Shortness of Breath	___ Feet Cold	___ Loss of Balance
___ Tension	___ Lights Bother Eyes	___ Hands Cold	___ Fever
___ Irritability	___ Change in Vision	___ Stomach Upset	___ Dizziness
___ Chest Pains	___ Head Seems Too Heavy	___ Constipation	___ Loss of Memory
___ Cold Sweats	___ Change in Urination	___ Depression	___ Fainting

Symptoms other than above: _____

_____

_____

Name of any other doctor consulted since your accident: _____
Treatment received: _____
How often did you receive care from the other doctor? _____
Have you previously been injured in a similar manner? Yes No Explain _____

_____

Have you lost any days of work? Yes No Dates lost: _____
Your Auto Insurance Company name: _____
Address: _____
Phone Number: _____
Name of other party involved: _____
Their Insurance Company: _____

Have you been contacted by an Insurance Adjustor or Company Representative regarding this claim?
Yes No

Do you have an attorney who has advised you in this case? Yes No
Name: _____
Address:_____
Phone Number: _____

Please fully explain how your accident happened: _____

_____

_____

_____

_____

_____

_____

_____

Which direction was your vehicle facing?

N

W E

S