Patient #_____ **Accidental Injury History** Date:_____

Automobile Accident Questionnaire
Name:_____ Date of injury:_____

Please describe the accident circumstances completely:

_____

_____

_____

List the Extent of the injuries as you know them:

_____

_____

_____

Circle the symptoms you have had since the accident:

Head injuries:
Headaches
Loss of memory
Loss of hearing
Lightheadedness
Fainting
Eye pain
Loss of Balance
Dizziness
Loss of hearing
Pain in the ears
Ear noises
Concussion
Lights bother eyes
Loss of smell or taste

Neck Injuries:
Stiffness, Soreness of the neck
Muscle spasm in the neck
Difficult neck movement
Grinding sounds in the neck

Shoulders, arms and chest injuries:
Shoulder pain, right or left
Pain between the shoulders
Can't raise arm or hand
Numbness or pain in arms, hands, or fingers
Cold hands
Shoulder, elbow or wrist pain
Loss of strength in arms or hands
Chest pain
Shortness of breath
Rib pain
Carpal tunnel syndrome

Abdominal symptoms:
Stomach, nausea, indigestion, gas, constipation, diarrhea

Low Back Symptoms:
Low back pain: Back is aggravated by working, lifting, stooping, or standing sitting, bending, coughing, or lying down
Disc problems
Difficulty in Standing

Leg Injuries:
Numbness extending into right or left leg
Pain into Buttocks, Knee joint, calves or ankles
Feet are cold
Swollen ankles
Pain in the hip, knee, ankles or feet

General Symptoms:
Depression
Fatigue
Insomnia
Loss of weight
Frequent urination
Nervousness
Jitteriness
Bruises
Lacerations
Broken bones
Knocked unconscious or stunned

Other:

_____

_____

_____

_____

Have you consulted with other Doctors for your injuries? _____Yes _____No
Did you report the injury to your foreman, employer, or police? _____Yes _____No

TYPE OF ACCIDENT
If auto accident, were you _____driver _____passenger _____pedestrian
If auto accident were you struck from _____behind _____right side _____left side _____front
If at work, describe details:_____

DETAILS AT TIME OF IMPACT:

_____Seat belt fastened _____Airbag deployed

_____Had pre warning that accident was going to happen

Head Position: _____Looking left _____Looking right _____Straight _____Turned around

Felt body go: _____Forward then back _____Back then forward

Did your body strike anything else in the car? _____Yes _____No If yes, explain_____

Did your vehicle strike other vehicle? _____Yes _____No

Was your vehicle struck by another vehicle _____Yes _____No

Amount of damage to the car? _____

AFTER THE ACCIDENT:

_____Taken to Hospital _____Went home

_____Went to Hospital later _____Went to Dr's office

Had: _____X-rays _____Lab _____Medications Please List_____

_____Cervical collar _____Follow up Instructions Other_____

Have you lost any days of work?_____ Dates:_____

Are your work activities restricted as a result of this accident? _____Yes _____No

INSURANCE COMPANIES INVOLVED

Name_____Phone_____
Address_____
_____
Policy and /or claim no._____

I hereby state that the information on both sides of this form is true and correct. I authorize the treating doctor at Discover Chiropractic to examine, make x-rays, treat me and do whatever is deemed necessary in accordance with the state statutes for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that Discover Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount is authorized to be paid directly to Discover Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination, treatment records, and prognosis to my employer, attorney, or insurance company.

Patient's Signature_____ Date:_____

Guardian Signature
Signature authorizing care:_____ Date:_____