## Automobile Accident Questionnaire

## Please answer all questions completely

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 if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

City			0	Marital	Date of	Home Phone
What vere the time and date of present injury?  What were the time and date of present injury?  What were the time and date of present injury?  What were the time and date of present injury?  Where did you feet pain immediately after the accident?  List the extent of injuries as you know them:  Did you require post accident hospitalization?   Yes   No    Check symptoms you have noticed since the accident:   Headache   Dizines   Dezines   Buzzing in Ears   Diarrhea     Neck Sitif   Pins and Needles in Arms   Loss of Balance   Back Pain Injury     Faiting   Sleeping Problems   Loss of Balance   Back Pain     Face Flushed   Pins and Needles in Legs   Constipation   Tension     Fare Flushed   Pins and Needles in Legs   Constipation   Tension     Fare Flushed   Pins and Needles in Legs   Loss of Smell   Fever     Nervousness   Numbness in Toes   Loss of Taste   Chest Pain     Cold Sweats   Shortness of Breath   Desire   No     Where were you taken after the accident?     Hospitalized?   Yes   No   If yes, admitted?   How long?     Name of Doctors     What treatment was given?     How long did you see the doctor?     How long did you see the doctor?     How vere you capable of working on an equal basis with others your age?   Yes   No     If so, what were the complaints?     How vere you capable of working on an equal basis with others your age?   Yes   No     If so, what were the complaints?   See   No	lame					
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(indicate if child, sudent, housewife, unemployed, relative)  Business   Company   Name   Location			Who ref	erred you to our of	ice?	
Name   Name   Location   Name   Location   Name   Name   Location   Name   Na	Occupation		(Indicate	e if child, student, h	ousewife, unemployed,	retired)
Spouse's Spouse's Spouse's Spouse's Spouse's Soc, Sec. # Employer Location  Please explain in detail how your accident happened  What were the time and date of present injury?  Where did you feel pain immediately after the accident?  List the extent of injuries as you know them:  Did you require post accident hospitalization?	Social	Business				Location
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Neck Stiff		□ Head	Seems too			
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Insurance Company	Driver of other	her vehicle (if any)			
Name   Name   Company   Policy No.	Manage				
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Dither vehicle was heading				·	
Were police notified?   Yes   No   No   Were you knocked unconscious?   Yes   No   If so, for how long?   You were struck from   Behind   Front   Left side   Right side   You were   Driver   Passenger   Front seat   Back seat   Using seat belts   Other protective devices      INDICATE ON THIS DIAGRAM WHAT HAPPENED   Use ONE OF THESE OUTLINES TO SKETCH THE SCENE OF YOUR ACCIDENT, WHITING IN STREET OR HIGHWAY NAMES OR NUMBERS.	You were he	eading   North   East   South	☐ West on		(street or highway)
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terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable Patient's Signature:  Guardian or Spouse's Signature:  DO NOT WRITE BELOW THIS LINE	Office will	be credited to my account on receipt. Howe	ever, I clearly underst	and and agree that a	Il services rendered m
Patient's Signature:  Guardian or Spouse's Signature:  Date  DO NOT WRITE BELOW THIS LINE					
Guardian or Spouse's Signature:					lately due and payable
DO NOT WRITE BELOW THIS LINE	Patient's	Signature:			
DO NOT WRITE BELOW THIS LINE	Guardian	or Spouse's Signature:		Date_	
		경기 강인 사람들이 가 시간이다고 요		•	
		DO NOT W	RITE BELOW THIS LIN	√E	
			and the second s		
Patient accepted?   Yes   No Doctor's Signature					