

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____

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

Address _____ City _____ State Zip _____

Email: _____ Occupation _____

Who referred you to our office? _____

Social Sec. # _____ Business Phone _____ Company Name _____

Company Address _____

Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of person who has made contact with you _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of Person who has made contact with you _____

Have you retained an attorney? Yes No Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ AM PM ____/____/____

You were heading? North South East West on _____ (street or highway)

Number of people in your vehicle _____

Were police notified? Yes No Did head strike windshield or object? Yes 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

Did you feel pain immediately after the accident? Yes No Later that day Next day When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was treatment given? _____

Was any doctor consulted after the accident? Yes No

If so, give doctor's name _____ D.C., M.D., D.O., D.D.S.

Doctor's Diagnosis _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

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

Since the injury, are your symptoms Improving? Getting worse? The same?

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Patient: _____

Date: _____

No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES
- NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION

P ___ Pain
 N ___ Numb
 S ___ Spasm

T ___ Tender
 H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

.....DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____