1169 Walker Road, Dover DE, 19904

(302) 736-1223

Patient Questionare - Auto Accident

Patient Name: ______________________ Today's Date: __________ Date of Exam: ____________

Provider: Chris t. Schellinger, D.C New Patient: **Yes** **No**

Basic Information about the Accident:

Date the Accident Occurred: ____________ Time of day when the Accident Occurred: ________ **AM** **PM**

Describe how the accident took place:

Describe the condition or symptoms caused by the accident:

Auto- Accident Specific Information:

You were the: **Driver** **Passenger** **Pedestrian**

Automobile you were in: Year ______ Make __________ Model ______________

Damage to your car: **Front** **Rear** **Pedestrian** **Driver Side** **Passenger Side** **Bumper** **Fender**

Damage Amount Estimate: **$** ______________ **Minor** **Major** **Totaled**

Other Automobile: Year ______ Make __________ Model ______________

Damage to other car: **Front** **Rear** **Pedestrian** **Driver Side** **Passenger Side** **Bumper** **Fender**

Where did the accident happen? Street Name/City/State: ______________________________

Was it? **Controlled Intersection** **Uncontrolled Intersection** **Not Intersection**

Was there a traffic light? **Green** **Red** **Turn Arrow** **Stop Sign** **N/A**

Were you: **Slowly Moving** **Moving** **Stopped**

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Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other: ________

Type of Impact: Rear End Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on Brake

How far did your car move? Did not move Moved 1 - 5 ft Moved 6 - 10 ft Moved over 10ft

Where were you seated in the car? ________ Wearing a seatbelt? Yes No

Shoulder Harness: Yes No Head Rest: Yes No Head Rest Position: Up Down

Is the car equipped with airbags? Yes No Did they deploy? Yes No

Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

On impact, your head was looking: Ahead Behind Up Down To the right To the left

On impact, you were: Thrown Forward Thrown Backwards Thrown Sideways Other: ________

Did your body hit anything inside the car? Yes No Body Part: ________ What did it hit? ________

Head Trauma? Yes No Loss of Consciousness? Yes No How long? ________

Do you remember the accident happening? Yes No

Did you go to the hospital? Yes No Name of hospital: ________ For how long?________

Taken by ambulance? Yes No

X-Rays taken? Yes No Areas taken: Neck Mid-back Low-back Other: ________

Medication given? Yes No RX: ________

Other Instructions:________ Follow up Date: ________

Additional Information Related to the Condition:

Describe your pain (Please Select One): Burning Sharp Dull Ache

What caused it?: ________

What aggravates it?: ________

What relieves it?: ________

Has the patient ever had the same or similar condition/symptoms previous to this most recent occurrence? Yes No When: ________

Describe:

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Please indicate any other healthcare providers who the patient has seen for the condition or symptoms:

Name:	Type of Licensure:	Date of Last Visit:
______________	______________	______________
______________	______________	______________

Please check any of the following symptoms you are now experiencing:

Headache	Dizziness	Light-Bothered Eyes	Diarrhea	Head feels too heavy	Neck Pain
Loss of Memory	Clumsiness	Cold Feet	Stiff Neck	Tingling in Arms/Legs	Ears Ring
Cold Hands	Sleeping Problems	Tingling in legs/feet	Face Flushed	Nausea	Back Pain
Numbness in Arms/Hands	Buzzing in Ears	Constipation	Nervousness	Numbness in Legs/Feet	Loss of Balance
Cold Sweats	Tension	Shortness of Breath	Fainting	Fever	Fatigue
Irritability	Loss of Smell	Chest/Rib Pain	Pain in arms/hands	Pain in Legs/Feet	Jaw Pain
Loss of Strength - Arms	Burning Muscle Pain	Loss of Strength - Legs	Difficulty Swallowing	Sharp/Shooting Pain	

Other: ______________________________

Have you experienced changes to:

Eyes (Sight)	Ears (Hearing)	Nose (Smell)	Mouth (Taste)	Bladder
Bowels	Sleep	Emotion	Appetite	

Please Explain: ______________________________

Have you missed work or school due to your injuries? **Yes** **No**

Do you smoke? **Yes** **No** **How many Packs?** ______________ **Day** **Week** **Month**

Do you drink alcohol? **Yes** **No** **Number of Drinks** ______________ **Day** **Week** **Month**

Notes:

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Medical History:

Have you ever been in our office before? **Yes** **No**

List any previous accidents (Automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1. ______________________________ **Date:** __________
2. ______________________________ **Date:** __________
3. ______________________________ **Date:** __________

Surgeries/Hospitalizations: ______________________________

Allergies (Please list all): ______________________________

Do you now, or have you ever had:

Heart Disease	**Diabetes**	**Cancer**	**Stroke**	**High Blood Pressure**	**Thyroid Problems**
Tuberculosis	**Prostate Disorder**	**Kidney Problems**	**Asthma**	**Ulcer**	**Seizure Disorder**

Other: ______________________________

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: ______________________________

Once you have completed these forms, please print and bring with you to your next appointment, thank you!