AUTOMOBILE ACCIDENT QUESTIONNAIRE

ABRAMS CHIROPRACTIC CLINIC

Please answer all questions completely and accurately.

Name: _____ Date & time of accident: _____

Please explain in detail how your accident happened: _____

_____

_____

_____

_____

Were you the ❑ Driver? ❑ Passenger? ❑ Front Seat? ❑ Back Seat?

Were you wearing a seat belt? ❑ Yes ❑ No

Were the police notified? ❑ Yes ❑ No

Was a citation issued to you? ❑ Yes ❑ No

the driver of the other car? ❑ Yes ❑ No

to the driver of the car you were in? ❑ Yes ❑ No

Where did you feel pain immediately after the accident? _____

_____

Did you find any bruises following the accident? ❑ Yes ❑ No Where? _____

Where were you taken after the accident? _____

What treatment was given? _____

Were X-rays taken? ❑ Yes ❑ No Were you given medication? ❑ Yes ❑ No

What type of medication? _____

Name and address of other physicians consulted for injuries sustained in this accident? _____

_____

What was previous physicians diagnosis? _____

Have you been involved in any previous accidents or injuries to this area? ❑ Yes ❑ No

If so, when and extent of injuries. _____

Have you lost any time from work due to these injuries? ❑ Yes ❑ No If so, what dates _____

Since your accident, are your symptoms ❑ Improving? ❑ Getting worse? ❑ Same?

Check the symptoms you have since the accident:

Musculo-skeletal

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

Genito-Urinary

- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

Female

- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain

Are you pregnant?

❑ Yes ❑ No

Nervous system

- ❑ Numbness
- ❑ Tingling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle jerk
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia
- ❑ Nervousness

PLEASE COMPLETE THE REVERSE OF THIS FORM

Check the symptoms you have since the accident:

Eye, Ear, Nose & Throat

- ❑ Sore throat
- ❑ Hoarseness
- ❑ Eye inflammation
- ❑ Eye strain
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing Loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficulty breathing thru nose
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Difficult speech

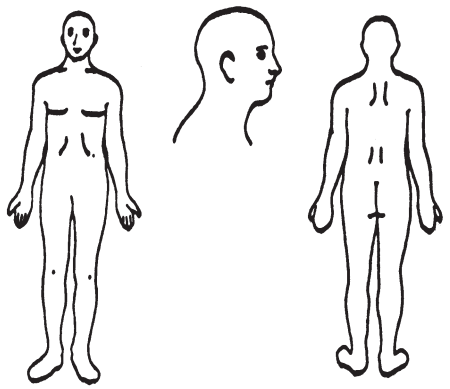
Gastro-Intestinal

- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Diarrhea
- ❑ Constipation
- ❑ Weight trouble

Cardio-Vascular-Respiratory

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent Cough
- ❑ Rapid heartbeat
- ❑ Blood pressure

Please mark your areas of pain on the figures below.



Necessary Insurance Information:

Have you retained an attorney? ❑ Yes ❑ No

Attorney's name, address and phone # _____

Your Insurance Company Name and Address _____

Your Insurance Policy # _____ Claim # _____

Your Insurance Adjuster's Name _____

Do you have Personal Injury Protection Coverage? ❑ Yes ❑ No

If you do have Personal injury Protection, it is our policy to bill your insurance carrier for your services, thus preventing accumulation of finance charges to your account.

If you do not have Personal Injury Protection, other financial arrangements can be made.

Insurance Company name and address of the other party involved _____

Adjuster's Name _____

Policy # _____ Claim # _____

If you were a passenger involved in the accident, please complete the following:

Name of person driving _____

Driver's Insurance Company Name and Address _____

Driver's Policy # _____ Driver's Claim # _____

Driver's Insurance adjuster's name _____

PATIENT'S SIGNATURE _____

Parent's or Guardian signature, should patient be a minor

Today's Date _____