PREMIER CHIROPRACTIC AND REHAB

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

Name:_____ Date of Accident:_____ Time:_____

Driver of vehicle in which you were injured: _____

Insurance Company: _____ Policy #:_____

Claim#_____ Phone #:_____

Driver of other vehicle: _____ Policy#:_____

Insurance Company#:_____ Claim#:_____

Adjuster:_____Phone#:_____

Have you retained an attorney? ___Yes ____No Attorney's Name: _____

Address: _____ Phone#:_____

Describe the accident in detail: _____

Were police notified? ___Yes ___ No

What was your position in the car? ____ Driver ____ Passenger

If passenger, where were you sitting in the car? ___ Front ___ Right Rear ___ Left Rear

What type of vehicle were you in? _____

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

Other vehicle was headed? ___ North ___East ___ South ___ West on _____(street or highway)

Was the impact from the: ___ Front ___Right Side ___ Left Side ___ Rear

Was the vehicle in: ___Park ___Neutral___ In Gear ___ Moving ___ Stopped

Were brakes being applied? ___ Was vehicle being shoved? ___ Forward ___ Backwards ___ Sideways

Were you shoved forward and whipped backwards at a rapid force, while hitting your head?_____

Did your head override headrest and springboard forward? _____

Did your hat or glasses end up in the back seat or under the rear window? ___ Yes ___ No

Did any part of your body hit any part of the interior? ___ Console ___ Steering Wheel ___Dashboard ___Windshield ___ Arm Rest ___ Side Door Window ___ Part of Body

Parts of body: ___Chest ___Chin ___Knee ___ Shoulder ___ Hand ___ Head

Were you wearing your seatbelt? ___Yes ___ No Did they break upon impact? ___ Yes ___ No

Was the impact: __Expected ___Unexpected If expected, did you brace for the impact? ___ Yes ___ No

If Yes, what did you brace against? ___ Did your seatbelt have a shoulder harness? ___Yes ___ No

Did it contribute to the pain? ___Yes ___No Which way was your head turned?_____

The headrest was? ___ Up ___Down How far was your head from the head rest at point of accident?

_____

Did the seat cushion your impact or spring you forward? _____

At the point of impact, where did you experience the pain sensation(s)? _____

Were you knocked unconscious? ___Yes ___No In a daze? ___Yes ___No

Did you go to the hospital? ___Yes ___No If yes, when? ___At time of accident ___Next day

How did you get to the hospital? ___Ambulance ___Own transportation

Name of hospital _____ Attended by Dr. _____

Were you x-rayed at the hospital?__Yes __No If so, what was the diagnosis? _____

Were you admitted to the hospital? ___Yes ___No How long did you stay? _____

Was any other doctor consulted after your accident? ___Yes ___No

If yes, Dr's Name: _____ 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, give details: _____

Is your pain constant? ___Yes ___No Is the pain on and off? ___Yes ___No

Sharp? __Yes ___No Dull? ___Yes ___No

Did you have numbness or tingling in your arm? ___Yes ___No In your hands? ___Yes ___No

In your fingers? ___Yes ___No In your legs? ___Yes ___No In your feet? ___Yes ___No

Do your knees ache __Yes __No Do you have cramps in your legs?__Yes __No

In your arms? __Yes __No

Do any of the following relieve your pain? __Heating pad __Hot bath __Shower __Ice pack __Rest __Medication

What type of work do you do? _____

Have you lost time at work because of the accident? ___Yes ___No

If yes, give dates lost: from _____ to _____

Are you required to lift over 10 lbs.? ___Yes ___No

Before the injury were you capable of working on an equal basis with others your age? ___Yes ___No

Totally disabled from _____ to _____

Partially disabled from _____ to _____