Court House Chiropractic – Auto Accident Questionnaire

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_ ACCT \_\_\_\_\_

Please circle or fill in the appropriate answer to the questions below.

Were you the: DRIVER/ FRONT SEAT PASSENGER/ BACK SEAT PASSENGER

Description of the vehicle you were in: MAKE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MODEL\_\_\_\_\_\_\_\_\_\_\_\_

Did you brace yourself with your arms: YES or NO

Portion of the vehicle hit: FRONT (R,L,C) REAR (R, L, C) SIDE (R/L)

Was your vehicle stopped at the time of the impact? YES or NO If no, your speed \_\_\_\_\_\_\_\_MPH

Was seatbelt worn: YES or NO Did the airbag deploy: YES or NO

Description of other vehicle involved: MAKE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MODEL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After the accident I went: HOME/ HOSPITAL/ FAMILY PHYSICIAN/ OTHER

 By: PRIVATE CAR/ AMBULANCE/ TREATED AT SCENE

Chief Complaint:

Lower back/ Mid back/ upper back shoulders/ neck pain, headaches, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms first appeared: IMMEDIATELY/ HOURS AFTER THE ACCIDENT/ THE NEXT DAY/ OR

 DAYS LATER (# of days )\_\_\_\_\_

Pain began: GRADUALLY/ SUDDENLY

Pain intensity is : MILD 1,2,3/ MODERATE 4,5,6/ SEVERE 7,8,9,10

Pain goes into: LEGS (RIGHT/LEFT)/ ARMS (RIGHT/LEFT)/ STAYS IN ONE PLACE

Has pain affected your daily living in any way?: WORK/ SLEEP/ SIT/ WALK/ BENDING OVER/ REACHING OVER HEAD/ CLEANING HOUSE/ BRUSHING TEETH/ PLAYING WITH KIDS/ DRIVING/ EXERCISING/ SHOPPING/ COOK/ STANDING/

Responsible party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Auto ins \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_