Automobile Accident Questionnaire

Accident Information

Name: _____ Date: _____

1. Date of Accident: _____ Time: _____am/pm

2. Driver of car: _____Where were you seated: _____

3. Owner of car: _____Year and Model of car: _____

4. Visibility at time of accident: poor / fair / good / other: _____

5. Road conditions at time of accident: icy/ rainy/ wet/ clear/ dark/ other: _____

6. Where was your car struck? Right/ left/ rear/ front/ side/ other: _____

7. Type of accident: □ head-on collision □ side collision □rear-end collision

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact: _____

10. Did you brace for impact? □Yes □No

11. Were you wearing a seatbelt? □Yes □No

12: Does your car have headrests? □Yes □No

13: Was your car braking? □Yes □No Was the other car braking? □Yes □No

14. Was your car moving at the time of the accident? □Yes □No

If yes, how fast would you estimate you were going? _____

15. How fast would you estimate the other car was traveling? _____

16. What was the position of your head and body at the time of impact?

□ Head turned left/ right □Body straight in sitting position □Head looking back

□ Body rotated left/ right □ Head straight forward □ Looking in rearview mirror

□ Looking at cell phone Other: _____

17. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle: _____

_____

18. As a result of the accident were you:

□ Rendered unconscious □ Dazed □ Other: _____

19. Could you move all parts of your body? □Yes □No

If no, why not? _____

20. Were you able to get out of the car and walk unaided? □Yes □No

If no, why not? _____

21. Did you have any cuts or bruises from the accident? □Yes □No

If so, where? _____

22. Describe how you felt immediately after the accident: _____

_____

How did you feel late that □ Day □ Night? _____

How did you feel the next day(s)? _____

23. Check symptoms apparent <u>since</u> the accident:

□ Headache	□ Loss of smell	□ Numbness in fingers
□ Neck pain/ stiffness	□ Loss of taste	□ Cold hands
□ Mid-back pain	□ Loss of memory	□ Cold feet
□ Low-back pain	□ Fatigue	□ Diarrhea
□ Tension	□ Constipation	□ Pain behind eyes
□ Shortness of breath	□ Fainting	□ Depression
□ Cold Sweats	□ Anxious	□ Sleeping problems
□ Loss of balance	□ Numbness in toes	□ Ringing/ buzzing in ears
□ Eyes sensitive to light	□ Other: _____	

24. Have you missed time from work? □Yes □No

If you missed time from work, how much time have you missed? _____

25. Did the accident occur during your work hours? □Yes □No

26. Did you seek medical help immediately/ soon after the accident? □Yes □No

If yes, how did you get there? _____

27. Doctor/ hospital/ clinic seen: _____ Date: _____

28. What was done? _____

Were x-rays taken? □Yes □No If yes, of what body part? _____

29. What treatments/ prescriptions were given? □Bed rest □ Brace □ Adjustments □ Medications If so, what medications? _____

30. What benefit(s) did you receive from treatment(s)? _____

_____

31. Date of last treatment: _____

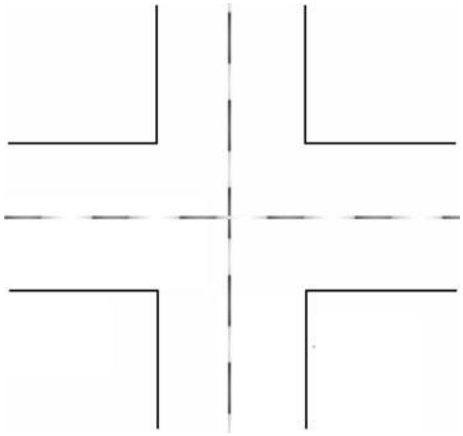
32. Are any of your activities of daily living any different now compared to before the accident? □Yes □No

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

33. Indicated on the diagram below how the accident happened:



Comments: _____

_____

_____

_____

_____

34. Do you have an attorney handling this case? □Yes □No

If yes, who? (name/ address) _____

_____

Insurance Information:

Patient's car insurance company name: _____

Insured's name (if other than patient): _____

Policy #: _____

Phone #: _____

Address: _____ City: _____ State/ Zip:_____

Claim # _____ Adjuster's name/phone:_____

_____

Other party's car insurance company name: _____

Insured's name (if other than patient): _____

Policy #: _____

Phone #: _____

Address: _____ City: _____ State/ Zip:_____

Claim # _____ Adjuster's name/phone:_____

_____

Assignment of Payment

My attorney and/ or insurance carrier are hereby requested and authorized to pay direct to Back to Life Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Back to Life Chiropractic the difference, if any between the total amount of charges on my account and the amount paid by the attorney ant/ or insurance carrier. It is further understood that I, the undersigned agree to pay Back to Life Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____