TWISTED
SPINE & JOINT CENTER

AUTO ACCIDENT QUESTIONAIRE

General Information:

Name _____ *Sex* ___ *Marital Status* ____ *Date of Birth* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home # _____ *Work#* _____ *Cell#* _____

Social Security # _____

Nature of Accident:

What was the date and time of this present injury? Date: _____ *Time:* _____ *AM/PM*

Please explain in detail how your accident happened. _____

_____

_____

Were you the ____ *driver* _____ *passenger* _____ *back seat driver's side* _____ *back seat passenger side?*

What direction was you headed? ____ *North* _____ *south* _____ *east* _____ *west*

What direction was the other vehicle headed? _____ *North* ____ *south* ____ *east* ____ *west*

Were you struck from _____ *behind* _____ *front* _____ *left side* _____ *right side*

Were you wearing a seat belt? YES NO

Did you come in contact with any objects in the car? YES NO
If yes, what? (i.e., windshield, steering wheel, etc.) _____

What parts of your body came in contact with the above object? _____

Were you unconscious as a result of the injury? YES NO

Were there any other passengers in the vehicle at the time of the accident? YES NO If yes, who and what are their ages and relationship to you? _____

Were the police called to the scene? YES NO Was an accident report taken? YES NO If yes, please provide a copy of the accident report for our files.

Were you taken to the hospital following the accident? YES NO By Ambulance? YES NO

Was any other doctor consulted after your accident? YES NO If yes, doctor's name? _____

Describe the doctor's diagnosis and treatment you received. _____

Are you still under a doctor's care: YES NO If yes, please explain. _____

Past History:

Have you ever injured this area before?: YES NO If yes, when? _____

Have you been involved in any previous accidents of any kind (personal injury, automobile accident, workers compensation)? YES NO If yes, please explain dates and details _____

Have you been treated previously by a Chiropractor? YES NO If yes, please explain _____

Have you enjoyed good health prior to this accident? YES NO If no, please explain (illness/injuries) ____

_____

Present Information/Disability:

Have you returned to work? YES NO If yes, date you returned _____

Job description: _____

Are your work activities restricted due to this accident? YES NO If yes, explain _____

_____

Do you notice any activity restrictions as a result of the injury? YES NO If yes, describe _____

_____

Since this injury, are your symptoms _____ improving _____ getting worse _____ or the same? Explain:

_____

Legal Representation:

Have you retained an attorney? YES NO If yes, give name, address and phone number _____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the doctors at Twisted Spine & Joint to perform upon me diagnostic and/or therapeutic procedures arising from my current or presently unforeseen conditions, which the doctor may consider necessary or advisable in the course of my health.

_____ _____

Patient Signature *Date*