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*