SHAW CHIROPRACTIC

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name:________________________________ Date:____/____/_______
Address:______________________________ Phone #:______________(H)
_____________________________________ ___________________(C)
Date of Birth__________________________ ___________________(W)
Occupation:___________________________

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 Driver____ Passenger____ Front Seat____ Back Seat____
What direction were you headed North____ East____ South____ West____
What direction was the other vehicle headed North____ East____ South____ West____
Were you struck from Behind____ Front____ Left Side____ Right Side____
How many vehicles were involved in the accident______________________________
Were you wearing a seat belt Yes____ No____
Did you come in contact with any objects in the car Yes____ No____ What objects__________
____

Were you unconscious as a result of the injury Yes____ No____ How long______________
Were you bleeding as a result of the injury Yes____ No____
Where did you feel pain or an unusual feeling immediately after the accident______________
Were the police notified Yes____ No____
Where were you taken after the accident______________
____

What treatment did you receive_________________
____

Was any other doctor consulted after your accident
Yes____ No____ Doctor's name_________________
DC____ MD____ DO____ DDS____
Describe the doctor's diagnosis_______________
____

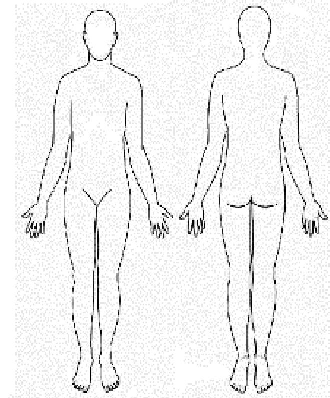
What treatment did you receive_________________
____

Are you still under a doctors' care Yes____ No____
Please explain______________________________
____
____
____

Circle any types of discomfort that you are having since the accident

Aching	Burning	Numbness
Sharp	Shooting	Stabbing
Stiffness	Throbbing	Tingling

Mark X's on the body where you are having pain or problems



Past History

Have you ever injured this area before Yes____ No____
Have you been involved in any previous accidents of any kind (personal injury, automobile accident, or workers' compensation) Yes____ No____ Please explain ______________________

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Have you been treated previously by a chiropractor Yes____ No____ Please explain__________

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____

Have you enjoyed good health prior to this accident Yes____ No____ Please explain__________

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____

Present Information

Have you returned to work Yes____ No____ Date ________________________________
Job description ____

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____

Are your work activities restricted as a result of this accident Yes____ No____
Please explain____

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Do you notice any activity restrictions as a result of this injury Yes____ No____
Please explain____

____

Since this accident, are your symptoms improving____ getting worse____ the same____
Please explain____

Legal Representation

Have you retained an attorney Yes____ No____ Name and address_______________________

____

____

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

____ ____________________________________
Patient signature Date

FOR OFFICE USE ONLY

Notes____

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