Time_____ Date_____

History

Name_____Social Security#_____

Address_____City_____Zip_____

Phone#_____Cell_____Age_____ DOB_____

Spouse's Name_____DOB_____Age of Childern_____

Your Employer_____ Work Address_____

Work #_____Position_____How Long? _____

Spouse's Employer_____How Long?_____Position_____work#_____

In case of emergency: Nearest Relative_____Phone #_____

Were you injured in an automobile accident?_____DOA_____

Were you injured at Work?_____DOA_____

I would like Conover Chiropractic Center to file the following insurance/s for my care. I have initialed the ones I would like filed. Do not file the ones I have not initialed.

_____**Primary Health Insurance** _____

_____**Secondary Health Insurance** _____

_____**Other Insurance (Liability, Attorney or Med pay)** please circle which you want to use and list name, attorney, adjuster, address claim# etc.)

_____

_____

_____

Signed_____ **Date** _____

Staff _____ **Date** _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____

Sex_____ Marital Status_____ Date of Birth _____ Home Phone_____

Address_____ City ____ State _____ Zip _____

Occupation _____

Who referred you to our office? _____

Social Sec. # _____Business Phone _____Company Name _____

Company Address _____

Please explain in detail how your accident happened? _____

_____

_____

Driver of other vehicle (if any) _____

Name of person who has made contact with you _____

Insurance Company_____

Policy No. _____

Claim No. _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company_____

Policy No. _____

Claim No. _____

Name of person who has made contact with you _____

Have you retained an attorney? ❑ Yes ❑ No ❑ Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ ❑ AM ❑ PM ____/____/_____

You were heading? ❑ North ❑ South ❑ East ❑ West on _____(street or highway)

Other vehicle was heading? ❑ North ❑ South ❑ East ❑ West on _____(street or highway)

Number of people in vehicle _____

Were police notified? ❑ Yes ❑ No Did head strike windshield or object? ❑ Yes ❑ No

Were you knocked unconscious ❑ Yes ❑ No If so, for how long _____

You were struck from? ❑ Behind ❑ Front ❑ Left side ❑ Right side

You were? ❑ Driver ❑ Passenger ❑ Front seat ❑ Back seat ❑ Using seat belts ❑ Other protective devices

Did you feel pain immediaely after the accident? ❑ Yes ❑ No ❑ Later that day ❑ Next day ❑ When _____

Where did you feel pain immediately after the accident?_____

Where were taken after the accident? _____

What treatment was given? _____

Was any doctor consulted after the accident? ❑ Yes ❑ No

If so, give doctor's name _____ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Doctor's diagnosis_____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, what were the complaints?_____

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptons ❑ Improving? ❑ Getting worse? ❑ The same?

Current chief Complaints

Name_____ **Date**_____

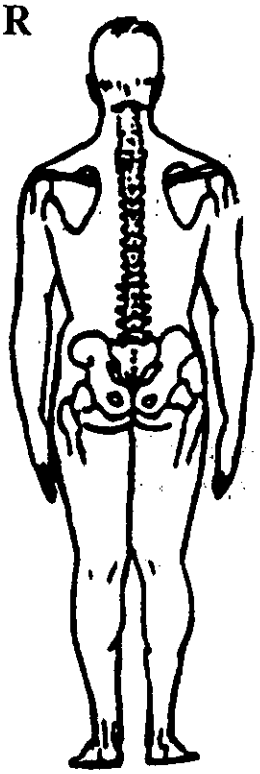
1. Body Part/System:_____
   Pain: _____ Stiffness_____
   Worse:_____ Better_____
   Quality: Dull ____Sharp ____Ache ____
   Throb____ Burn _____
   Radiate: _____
   Severity (1-10) _____
   Constant ____ Off/On ___ Periodic: ____

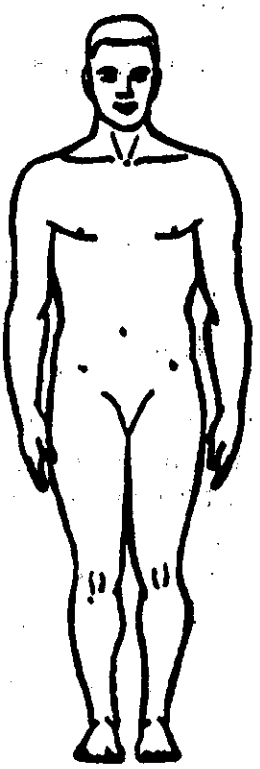
2. Body Part/System:_____
   Pain: _____ Stiffness_____
   Worse: _____ Better_____
   Quality: Dull ____Sharp ____Ache ____
   Throb____ Burn _____
   Radiate: _____
   Severity (1-10) _____
   Constant ____ Off/On ___ Periodic: ____

3. Body Part/System _____
   Pain: _____ Stiffness_____
   Worse _____ Better_____
   Quality: Dull ____Sharp ____Ache ____
   Throb____ Burn _____
   Radiate: _____
   Severity (1-10) _____
   Constant ____ Off/On ___ Periodic: ____

COMPLETE THESE DIAGRAMS

R





Have you ever had or been treated for any of these complaints prior to this Crash?
____ yes ____no. Which _____

Please list any medications taken on a regular basis and why you are taking them:

_____

_____

Please list any surgery/operation you have had: _____

_____

Fractures/broken bones: _____

_____

Have you ever been diagnosed with cancer? _____ yes _____no. If yes where/what kind.

_____

Are you a smoker ____ yes ____no