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

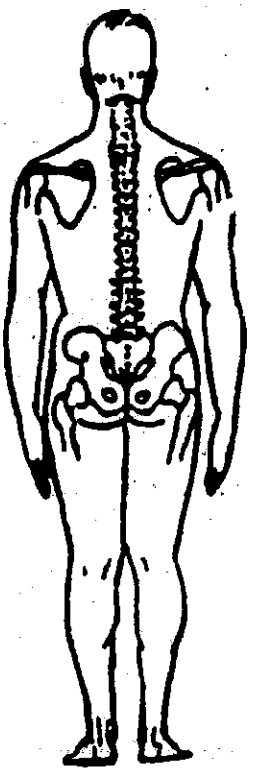
Name_____ **Date**_____

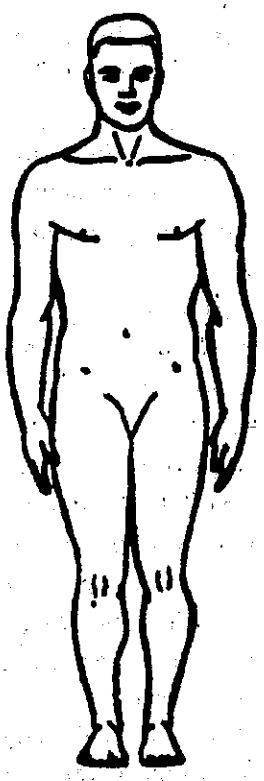
1. Body Part/System:_____
   Pain: _____ Stiffness_____
   Worse:_____ Better_____
   Quality: Dull ____Sharp ____Ache ____
   Throb____ Burn _____
   Radiate: _____
   Severity (1-10) _____
   Constant ____ Off/On ___ Periodic: ____

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





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.

_____

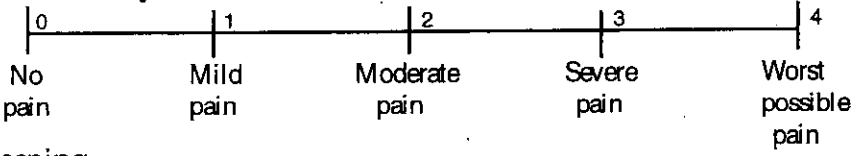
Are you a smoker ____ yes ____no

Functional Rating Index

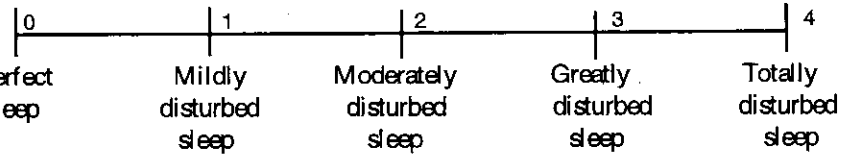
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number which most closely describes your condition right now.

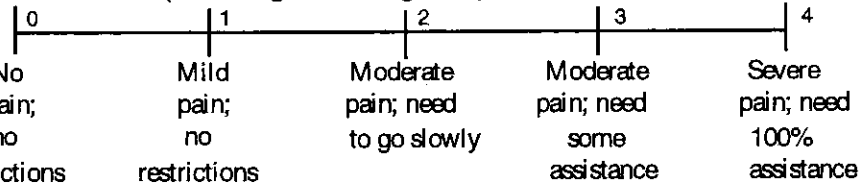
1. Pain Intensity



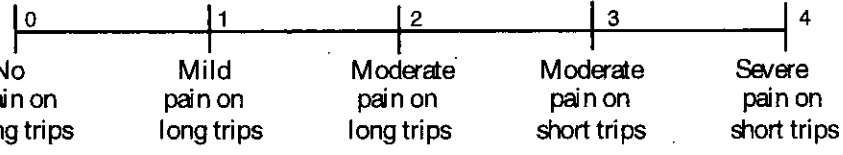
2. Sleeping



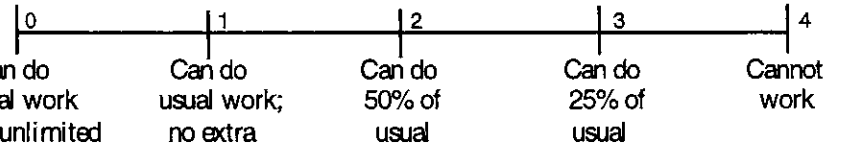
3. Personal Care (washing, dressing, etc.)



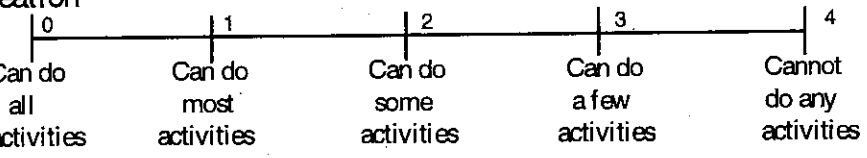
4. Travel (driving, etc.)



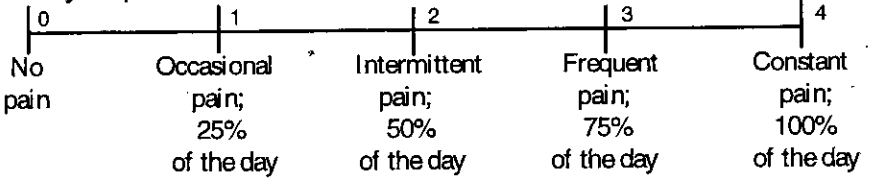
5. Work



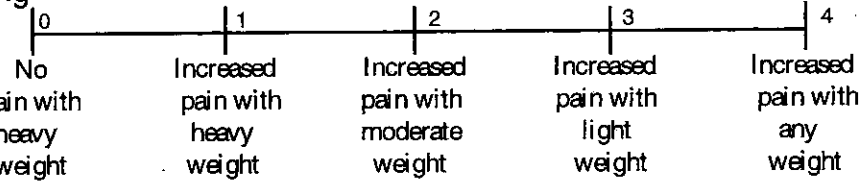
6. Recreation



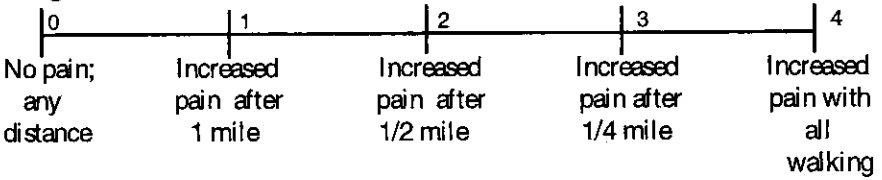
7. Frequency of pain



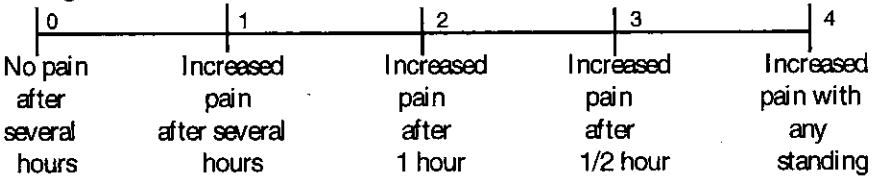
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

_____

Signature

_____

Date

Conover Chiropractic Center

Personal Injury History Time_____Date_____

Name_____SS#_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____

Email address_____DOB_____

Spouse's Name_____Phone#_____

Your Employer_____Work #_____

Spouse Employer_____Work#_____

In Case of emergency: Nearest Relative/relation_____Phone#_____

Were you injured in an auto accident or work injury (circle one)_____Date of Accident_____

Family Doctor_____Phone/Fax_____

How did you hear about us?_____

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 one/s I have not initialed

_____Primary Health Insurance _____

_____Second Health Insurance_____

_____Other insurance (Liability, Attorney, Med Pay_ please circle which you want to use and list the name of attorney, insurance, insurance adjusters name, address, fax and phone numbers along with your claim#)

_____

_____

_____

Signed_____Date_____

Staff/Dr._____Date_____