

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Patient _____ Date _____
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 immediately 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 symptoms Improving? Getting worse? The same?

Current chief Complaints

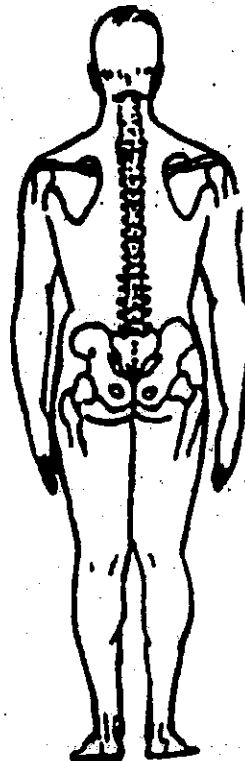
Name _____

Date _____

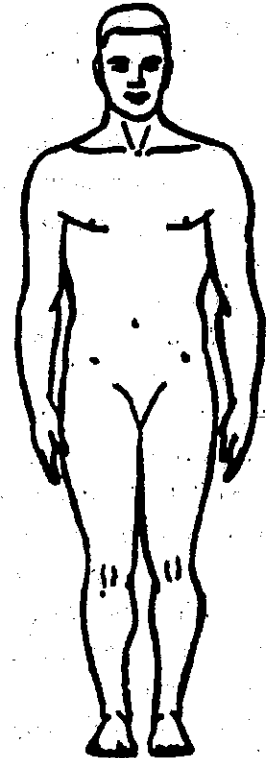
1. Body Part/System: _____
Pain: _____ Stiffness _____
Worse: _____ Better _____
Quality: Dull _____ Sharp _____ Ache _____
Throb _____ Burn _____
Radiate: _____
Severity (1-10) _____
Constant _____ Off/On _____ Periodic: _____

COMPLETE THESE DIAGRAMS

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: _____



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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

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

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 _____