

## **AUTOMOBILE ACCIDENT QUESTIONNAIRE**

Patient's Name: \_\_\_\_\_  
(last name) (first name) (m.i.)

Today's Date: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

**Your position in the vehicle:**

- Driver  
 Passenger Location  Left  Middle  Right  
 Other \_\_\_\_\_  Front Passenger  Rear Passenger  Third Seat (rear)

**Vehicle size:**

- Subcompact  Full-size  
 Compact  Mini  
 Mid-size  Light  
 Heavy  Other \_\_\_\_\_

**Vehicle type:**

- Car  Pickup  
 Van  Truck  
 Station Wagon  Bus  
 Other \_\_\_\_\_

**Speed of your vehicle:**

- Stopped  Moving Moderately  
 Parked  Moving Fast  
 Slowing  Moving at apprx \_\_\_\_MPH  
 Moving Slowly

**Why Vehicle was slowed or stopped:**

- Traffic Signal  Parking  
 Pedestrian  Traffic  
 Stop Sign  Busy Intersection

**Collision Type:**

- Driver Side Impact  Head On Collision  Passenger Side Impact  Rear Impact  
 Front Impact  Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE

**Vehicle size:**

- Subcompact  Full-size  
 Compact  Mini  
 Mid-size  Light  
 Heavy  Other \_\_\_\_\_

**Vehicle type:**

- Car  Pickup  
 Van  Truck  
 Station Wagon  Bus  
 Other \_\_\_\_\_

# Intelligent Chiropractic

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## CONDITIONS AT THE TIME OF THE ACCIDENT:

<u>Time of day:</u>	<u>Road Conditions:</u>	<u>Visibility:</u>	<u>Visibility compromised by:</u>
<input type="checkbox"/> Full daylight	<input type="checkbox"/> Dry	<input type="checkbox"/> Excellent	<input type="checkbox"/> Brightness
<input type="checkbox"/> Dusk	<input type="checkbox"/> Damp	<input type="checkbox"/> Good	<input type="checkbox"/> Darkness
<input type="checkbox"/> Night	<input type="checkbox"/> Wet	<input type="checkbox"/> Fair	<input type="checkbox"/> Rain
	<input type="checkbox"/> Snow	<input type="checkbox"/> Poor	<input type="checkbox"/> Snow
	<input type="checkbox"/> Ice		<input type="checkbox"/> Fog
	<input type="checkbox"/> Patchy Ice/Snow		<input type="checkbox"/> Traffic

## THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

<b><u>Were you</u></b>	<b><u>Restraints: (check all that apply)</u></b>
<input type="checkbox"/> Totally unaware that the accident was impending	<input type="checkbox"/> Seat belt
<input type="checkbox"/> Aware that the accident was impending	<input type="checkbox"/> Shoulder harness
<input type="checkbox"/> Aware that the accident was impending and braced for it	<input type="checkbox"/> No restraints
<b><u>Was your foot on the brake pedal?</u></b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Knocked off by impact	
<b><u>Was the air bag deployed?</u></b>	<b><u>What position was YOUR headrest in?</u></b>
<input type="checkbox"/> Car not equipped with air bag	<input type="checkbox"/> High position
<input type="checkbox"/> Air bag deployed	<input type="checkbox"/> Middle position
<input type="checkbox"/> Air bag not deployed	<input type="checkbox"/> Low position
<b><u>Position of YOUR head at time of impact?</u></b>	<b><u>Was your head thrown?</u></b>
<input type="checkbox"/> Facing straight ahead	<input type="checkbox"/> Backward and then forward
<input type="checkbox"/> Tilted forward	<input type="checkbox"/> Forward then backward
<input type="checkbox"/> Rotated to the left	<input type="checkbox"/> To the left <input type="checkbox"/> To the left then right
<input type="checkbox"/> Rotated to the right	<input type="checkbox"/> To the right <input type="checkbox"/> To the right then left
<b><u>Position of Your body at time of impact</u></b>	<b><u>Was your body thrown...?</u></b>
<input type="checkbox"/> Straight	<input type="checkbox"/> Backward and then forward
<input type="checkbox"/> Tilted forward	<input type="checkbox"/> Forward then backward
<input type="checkbox"/> Rotated to the left	<input type="checkbox"/> To the left <input type="checkbox"/> To the left then the right
<input type="checkbox"/> Rotated to the right	<input type="checkbox"/> To the right <input type="checkbox"/> To the right, then the left
	<input type="checkbox"/> Across the vehicle
	<input type="checkbox"/> Outside the vehicle <input type="checkbox"/> Under the vehicle
<b><u>Damage to vehicle YOU were in:</u></b>	<b><u>Citations:</u></b>
<input type="checkbox"/> Incurred minimal damage	<input type="checkbox"/> None issued
<input type="checkbox"/> Incurred moderate damage	<input type="checkbox"/> Yourself
<input type="checkbox"/> Incurred severe damage	<input type="checkbox"/> Driver of vehicle patient was a passenger of
<input type="checkbox"/> Was totalled	<input type="checkbox"/> Driver of other vehicle
<input type="checkbox"/> Not known	<input type="checkbox"/> Not sure

**WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?**

**Head**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Left Arm**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Right Arm**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Torso**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Left Leg**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**Right Leg**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Steering wheel   | <input type="checkbox"/> Right door   |
| <input type="checkbox"/> Dashboard        | <input type="checkbox"/> Left window  |
| <input type="checkbox"/> Windshield       | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Armrest          | <input type="checkbox"/> Console      |
| <input type="checkbox"/> Headrest         | <input type="checkbox"/> Gear shift   |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Front seat   |
| <input type="checkbox"/> Left door        | <input type="checkbox"/> Backseat     |

**IMMEDIATELY FOLLOWING THE ACCIDENT:**

**Did you lose consciousness?**

- Yes  
 No

**Immediately following the accident, did you feel?**

- |                                      |                                    |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Dizzy       | <input type="checkbox"/> Weak      |
| <input type="checkbox"/> Dazed       | <input type="checkbox"/> Nervous   |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Nauseated |

**Were you able to walk unaided?**

- Yes  
 No

**Where did you go...?**

- |  |   |
|--|---|
| <input type="checkbox"/> Drove home        | <input type="checkbox"/> Drove to work      |
| <input type="checkbox"/> Was driven home   | <input type="checkbox"/> Was driven to work |
| <input type="checkbox"/> Drove to hospital | <input type="checkbox"/> Drove to school    |

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- Was driven to hosp    Was driven to school  
 Taken to hospital via ambulance

**Next day discomfort**    increased    decreased    same

**Did your major complaints exist before the accident?**    Yes    No

**In what areas did you IMMEDIATELY feel pain?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Fingers                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**In what areas did you experience lacerations (cuts)?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Fingers                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**At the hospital, what areas were x-rayed?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm                             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist                           | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest      | Fingers                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen    | Buttock                         | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Pelvis |                               |                                |       |                               |                                |

**Where did you experience pain on the day FOLLOWING the accident?**

- |                                     |          |                               |                                |       |                               |                                |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck       | Arm      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back   | Wrist    | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs       | Hand     | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |

# *Intelligent Chiropractic*

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Chest  
 Abdomen  
 Low Back

Fingers  
Buttock  
 Pelvis

Left  Right  
 Left  Right

Foot  Left  Right  
Toes  Left  Right

## **Disclaimer**

- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me.
- I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt.
- I, also authorize the release of any health information necessary to process this claim.
- I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.
- I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable.
- In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_