ELEVATE CHIROPRACTIC

Date: _____

# Automobile Accident Questionnaire

## Patient Information

Patient Name:_____ Birthday: _____/_____/_____
Address:_____ City:_____ State: ____ Zip:_____
Sex: _____ Marital Status: _____ Spouse's Name: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone # :_____ Email: _____
Occupation: _____ Employer:_____
Emergency Contact:_____ Relationship:_____ Phone #: _____
How were you referred to our office? :_____

## Insurance Information

Auto Insurance Company:_____ Policy #_____
Claim #: _____ Adjuster's Name:_____ Phone #: _____
Please explain, how your accident occurred:_____
_____
Driver of other vehicle, if any: _____
Other driver's insurance company:_____ Phone #:_____

Have you retained an attorney? ○ Yes ○ No ○ Not Yet ○ Other: _____
Attorney's Name:_____ Phone #: _____
Address:_____ City:_____ State:____ Zip:_____

## Accident Information

Time and Date present injury occurred: _____:_____ AM/PM on _____/_____/_____ (mm/dd/year)
You were heading? ○ North ○ South ○ East ○ West on _____ (Street/Highway)
Number of people in your vehicle: _____ Were police notified? (Yes/No) Were you knocked unconscious? (Yes/No)
Were you struck from? ○ Behind ○ Front ○ Left Side ○ Right Side ○ Other: _____
Were you? ○ 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 ○ Other: _____
Where did you feel pain immediately after the accident?: _____
Where were you taken after the accident? :_____
Was treatment given? ○ Yes ○ No 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? : _____

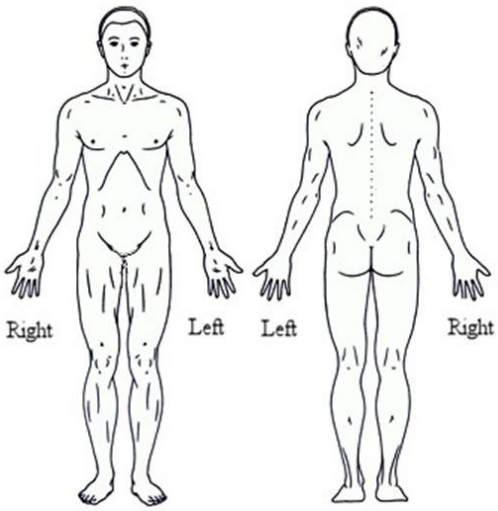
How often did you see the Doctor? : _____
How long did you see the Doctor? : _____
Before the injury, were you capable of working on an equal basis with others your age? ○ Yes ○ No
Are you work activities restricted as a result of this accident? ○ Yes ○ No
Since the injury, are your symptoms: ○ Improving ○ Getting Worse ○ Staying the Same

## Health Questionnaire

Please check the box to indicate your current health issues:

| | Musculo-Skeletal System | | Genito-Urinary System | | Gastrointestinal System | | Cardiovascular/Respiratory System |
|---|---|---|---|---|---|---|---|
| | Low back pain | | Bladder trouble | | Poor appetite | | Chest pain |
| | Shoulder blade pain | | Excessive urination | | Excessive hunger | | Pain over heart |
| | Neck pain | | Scanty urination | | Difficult chewing | | Difficult breathing |
| | Arm pain | | Painful urination | | Difficult swallowing | | Persistent cough |
| | Leg pain | | Discolored urine | | Excessive thirst | | Coughing blood |
| | Swollen joints | | | | Nausea | | Coughing phlegm |
| | Painful joints | | **Female** | | Vomiting food | | Rapid heartbeat |
| | Stiff joints | | Vaginal bleeding | | Vomiting blood | | Blood pressure issues |
| | Sore muscles | | Vaginal discharge | | Abdominal pain | | Heart problems |
| | Weak muscles | | Vaginal pain | | Diarrhea | | Lung problems |
| | | | Breast pain | | Constipation | | Varicose veins |
| | | | Lumps in breast | | Black Stool | | |
| | | | | | Hemorrhoids | | |
| | | | | | Liver trouble | | |
| | | | | | Gallbladder trouble | | |
| | | | | | Weight trouble | | |

| | Nervous System | | Eye, Ear, Nose & Throat |
|---|---|---|---|
| | Numbness | | Eye Strain |
| | Loss of feeling | | Eye inflammation |
| | Paralysis | | Vision problems |
| | Dizziness | | Ear pain |
| | Fainting | | Ear discharge |
| | Headaches | | Hearing loss |
| | Muscle jerking | | Nose pain |
| | Convulsions | | Nose bleeding |
| | Forgetfulness | | Nose discharge |
| | Confusion | | Difficult breathing through nose |
| | Depression | | Sore gums |
| | | | Dental problems |
| | | | Sore mouth |
| | | | Sore throat |
| | | | Hoarseness |
| | | | Difficult Speech |




**FEMALE ONLY.** My signature indicates that, "This is to certify, to the best of my knowledge that I am not pregnant at this time. I hereby authorize the chiropractic clinic/doctors to take x-rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present"

Printed Name _____ Signature _____ Date _____

**I hereby authorize this office and its doctors to administer care to myself or my child as they deem necessary**

_____

**Signature of Patient (or parent if a minor)** **Date**