

**CHIROPRACTIC**  
Automobile/PI Accident or Work Comp Questionnaire

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**HR#:**

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.  
Thank you.

**Please answer all questions completely.**

Please explain in detail how your accident happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

List the extent of your injuries as you know them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you require post-accident hospitalization?  Yes  No

**Check symptoms you have noticed since the accident:**

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Head Seems to Heavy	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Neck Stiff
<input type="checkbox"/> Pins and Needles in Arms	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Pins and Needles in Legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Irritability
<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Stomach Upset		

Symptoms other than above: \_\_\_\_\_  
\_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Hospitalized?  Yes  No If yes, admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Name of Doctor(s): \_\_\_\_\_

What treatment was given? \_\_\_\_\_

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
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\_\_\_\_\_  
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Was any other doctor consulted after your accident?  Yes  No

If so, what was the doctor's name? \_\_\_\_\_ D.C., M.D., D.O., D.D.S.

What was the 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 this injury are your symptoms ...  Improving?  Getting worse?  Same?

Driver of other vehicle (if any):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his/her name and address \_\_\_\_\_

You were heading North/ East/ South/ West on \_\_\_\_\_ (street or highway)

Other vehicle was heading North/ East/ South/ West on \_\_\_\_\_ (street or highway)

Were police notified?  Yes  No

Were you knocked unconscious?  Yes  No If yes, for how long? \_\_\_\_\_

You were struck from Behind/ Front/ Left Side/ Right Side \_\_\_\_\_

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_

Date \_\_\_\_\_