

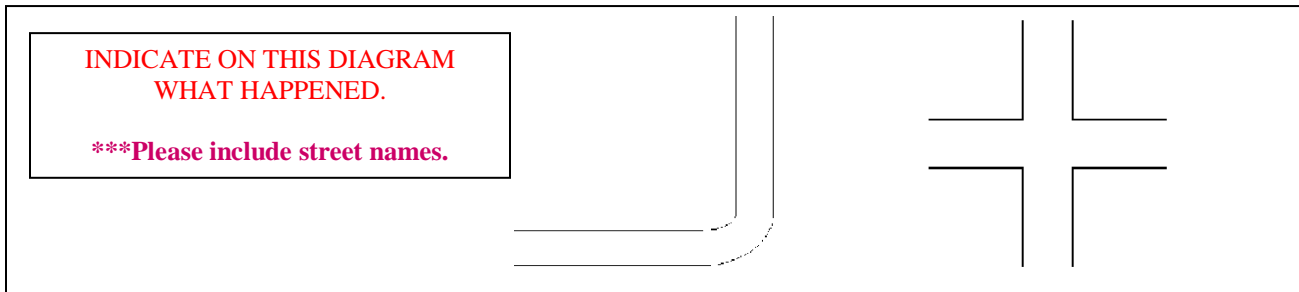
Potomac Valley Chiropractic – Automobile Accident Questionnaire

Please answer all questions **completely**.

Name: _____ D.O.B. _____
 Address: _____ City _____ State _____ Zip _____
 Home Phone: _____ Cell #: _____ Work #: _____
 Occupation: _____ Marital Status: M S W D
 Number of children: _____ Boys _____ Girls
 Name and Number of Emergency Contact: _____

Date of Accident: _____ Time of Accident: _____

Please provide a brief description of how your accident happened:



Make/model of your car: _____ Make/model of other car: _____
 Speed of your car at the time of accident: _____ Speed of the other car at the time of accident: _____
 Were police notified? Yes No
 You were struck from Behind Front Left side Right side
 You were Driver Passenger Front seat Back seat
 Were you using a seatbelt? Yes No
 Did the airbags deploy? Yes No
 What was your vehicle doing immediately prior to impact? _____ Accelerating? Y/N
 What were the road conditions? Wet Dry Icy Other: _____
 How was the visibility? Good Poor Night time Daytime Other: _____
 What was the position of your headrest? Properly Adjusted Down _____
 Were you prepared for impact? Y/N Foot on break at time of accident? Y/N
 What the position of your head and neck prior to impact? Straight ahead Down Up To the side
 Did you feel pain immediate after the impact? Y/N Where? _____
 Did you lose consciousness? Y/N
 Were you taken to the hospital? Y/N If yes, admitted? Y / N Name of Hospital _____
 What treatment was given? _____
 If not hospitalized, where did you go immediately after accident? _____
 Was any other doctor consulted after your accident? Y/N If so, what was the doctor's name? _____
 What treatment was given? _____

Check all symptoms felt after accident.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Buzzing in ears |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Pins/needles in legs | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of smell/taste |
| <input type="checkbox"/> Pins/needles in arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Irritability | <input type="checkbox"/> Diarrhea |

Past Health History

Please check any past/current illness:

Hypertension Arthritis Diabetes Heart Disease
 Anxiety Cancer: Type _____ Tuberculosis Headaches
 Depression Seizure Disorder Asthma Migraines
 Allergies Osteoporosis Carpel Tunnel Hernia

Please check any current medications you are taking:

Hypertensives Diabetic/Insulin Cholesterol Lowering Cholesterol Killers
 Pain Killers Tylenol/Advil Allergy Aspirin
 Asthma Steroid/Anti-inflammatory Others: _____

Past Surgeries:

Major surgery What/When: _____
Minor surgery What/When: _____

Is this complaint related to an injury at work? Yes No
Is this complaint related to a car accident? Yes No

Past Automobile Accidents

< 1 yr < 2 - 3 yrs. > 5 yrs.
Year: _____ Brief Description: _____

Family History

Check any that apply to your family history.

Mental Illness Cancer: Type _____ Diabetes Heart Disease
 Obesity Arthritis High Blood Pressure
 Osteoporosis Other: _____

Do any family member have a physical impairment? Yes No

Parents are: Deceased Alive

Does current problem interfere with:

Driving Sleeping Lifting Children Computer work
 Bending Standing Housework Exercise
 Sitting Running Grooming Twisting
 Other (Describe): _____

Insurance Information

Name of Car Insurance Company: _____
Policy #: _____
Insurance Company Address: _____
Name of Claim Adjuster: _____
Phone # of Claim Adjuster: _____ Fax #: _____
CLAIM NUMBER: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Date _____

Guardian's Signature: _____

Doctor's Signature: _____