Potomac Valley Chiropractic – <u>Automobile Accident Questionnaire</u>

Please answer all questions **<u>completely</u>**.

Name: _____ D.O.B. _____

Address: _____City _____ State _____ Zip _____

Home #: _____ Cell #: _____ Work # _____

Occupation: _____ Height: __'__" Weight: _____ lbs
Number of Children: _____ Boys _____ Girls Marital Status: M S W D

Name & Number of Emergency contact: _____

Please provide a brief description of how your accident happened:

_____

_____

1) What was the date of the accident? _____ Time of accident: _____ AM or PM
2) How many vehicles were involved in the accident? _____
3) What was the estimated damage to the vehicle you were in?

_____

4) What state did the accident occur in? _____ City? _____
5) What street or intersection were you on when the accident occurred?

_____

6) What direction were you traveling in? _____
7) What type of impact was the auto accident? _____
8) Did your vehicle hit anything after the accident? If YES, please describe

_____

9) Where were you sitting in the vehicle during the accident? _____
10) Did you know the accident was coming? _____
11) What type of vehicle were you in? _____
12) What type of vehicle impacted you? _____
13) At the time of the impact, how fast was your vehicle going? _____
14) At the time of the impact, how fast was the other vehicle moving? _____
15) During and after the crash what happened to your vehicle? (Circle all that apply)
- Kept going straight - Spun around
- Kept going straight hitting a car in front - Spun around and hit a stationary object
- Was hit by another vehicle - Hit a stationary object

16) Did you lose consciousness during the accident? YES or NO
17) Did your airbags deploy? YES or NO
18) How was the visibility? __Good __ Poor __ Dry __Icy __Other: _____
19) How was your head positioned during the accident? _____
20) How was our torso positioned during the accident? _____
21) How were your hands positioned during the accident? _____
22) Did your head hit anything during the accident? - NO - if YES, please describe

_____

23) Did your face hit anything during the accident? –No - If YES, please describe

_____

24) Did your shoulders hit anything during the accident? – NO - if YES, please describe

_____

25) Did your neck hit anything during the accident? – NO - if YES, please describe

_____

26) Did your chest hit anything during the accident? – NO - if YES, please describe

_____

27) Did your hips hit anything during the accident? – NO - if YES, please describe
_____
28) Did your knees hit anything during the accident? – NO - if YES, please describe
_____
29) Did your feet hit anything during the accident? – NO – if YES, please describe
_____
30) What kind of headrest was in your vehicle?
31) Where was the headrest positioned on your head? _____
32) Did you have your seatbelt on during the accident? _____
33) Did you slide out of your seatbelt during the accident? _____
34) What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	-mirror	-side window
- steering wheel	- front bumper	- knee bolster	- front right door
- dashboard	- trunk	- back right door	- rear window
- seat frame	- front left door	- completely totaled	-back left door

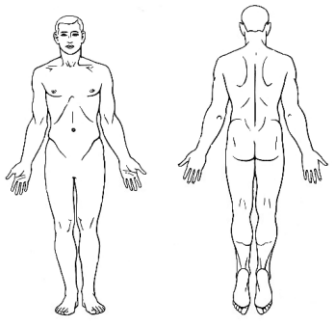
35) Choose the items the dented inward
- floorboards - side door - dashboard

36) Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37) Did you go to the hospital? If no, why and do not answer 38-43
_____
38) How did you get to the hospital? _____
39) What was the name of the hospital? _____
40) Were you hospitalized over night? _____
41) Circle what you were prescribed at the hospital
- Pain medication - Muscle relaxors - Neck brace

42) Did you receive any stitches for any cuts at the hospital? _____
43) Were X-RAYS taken at the hospital? If yes, which area was taken?
_____
Was any other doctor consulted after your accident? Yes or NO, if so what was the doctor's name? What treatment was given? _____
_____

Mark on the drawings below where you have pain/symptoms.



How long have you had this problem for?
_____

When did your problem start?
_____

***How often do you experience your symptoms?**

□ Constantly (76-100% of the time)	□ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time)	□ intermittently (1-25% of the time)

*** How would you describe the type of pain?**

□ Sharp	□ Numb	□ Stiff
□ Dull	□ Tingly	□ Other
□ Diffuse	□ Sharp with motion	
□ Achy	□ Shooting with motion	
□ Burning	□ Stabbing with motion	
□ Shooting	□ Electric like with motion	

*** How are your symptoms changing with time?**
□ Getting Worse □ Staying the Same □ Getting Better

*** Using a scale from 0-10 (10 being the worst), how would you rate your problem?**
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

*** How much has the problem interfered with your work?**
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

*** How much has the problem interfered with your social activities?**
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

*** Who else have you seen for your problem?**
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

*** Do you consider this problem to be severe?**
□ Yes □ Yes, at times □ No
*** What aggravates your problem?**
_____

***What concerns you the most about your problem; what does it prevent you from doing?**
_____

*** How would you rate your overall Health?**
□ Excellent □ Very Good □ Good □ Fair □ Poor

*** What type of exercise do you do?**
□ Strenuous □ Moderate □ Light □ None

*** Indicate if you have any immediate family members with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

*** For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Present	Past	***Present***	Past	***Present***	Past
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco
□	□ Low Back Pain	□	□ Angina	□	□ Drug/ Alcohol
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Epilepsy	□	□ Systemic Lupus
□	□ Kidney Disorders	□	□ Depression	□	□ HIV/AIDS
□	□ Wrist Pain	□	□ Bladder Infection		
□	□ Hand Pain	□	□ Painful Urination		
□	□ Hip Pain	□	□ Loss of Bladder Control		
□	□ Dermatitis/Eczema/Rash				
□	□ Upper Leg Pain	□	□ Prostate Problems		
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer		
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		

□	□ Cancer	□	□ General Fatigue
□	□ Tumor	□	□ Muscular In coordination
□	□ Asthma	□	□ Visual Disturbances
□	□ Chronic Sinusitis	□	□ Dizziness

FOR FEMALES ONLY

Present	Past	
□	□	Birth Control Pills
□	□	Hormonal Replacement
□	□	Pregnancy

*** List all prescription medications you are currently taking:**

_____

*** List all of the over-the-counter medications you are currently taking:**

_____

*** Do you have any allergies? _____Yes _____ No**

If YES, list them:_____

*** List all surgical procedures you have had:**

_____

*** What activities do you do at work?**

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

*** What activities do you do outside of work?**

_____

*** Have you ever been hospitalized?** □ No □ Yes

if yes, why_____

*** Have you had significant past trauma? (Falls, accidents, car accidents)**

□ No □ Yes If yes, date them and give a brief description

_____

***Anything else pertinent to your visit today: _____**

Insurance Information

Name of Car Insurance Company: _____
Policy #: _____ Claim #: _____
Insurance Company Address: _____
_____
Name of Claim adjuster: _____
Phone Number of Claim Adjuster: _____
Fax Number of Claim Adjuster: _____

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 mea 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 for me will be immediately due and payable.

Patient's Signature: _____ Date: _____
(Or Guardian if Minor)

Doctor's Signature: _____