

COLLARD CHIROPRACTIC & ACUPUNCTURE

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient: _____ Date: _____
Social Security No.: _____ - _____ - _____ Date of Birth: _____ Age: _____ Sex: M F
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Is it ok to text this phone? Y N
E-mail address _____ Marital Status: _____
Employer: _____ Address: _____
Name of Spouse _____ No. of Children: _____
Spouses Employer: _____ Address: _____
How did you learn of this clinic? _____ If referred who referred you? _____

Please explain in detail how your accident happened? _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____ address _____ Phone No: _____

Claim No. _____ Policy No. _____

Name of Person who has made contact with you _____

Have you retained an attorney? Yes No Not Yet

If so, his/her name, address & phone # _____

When did the accident happen? time: _____ AM PM _____ / _____ / _____

You were heading? North South East West on _____ (street or highway)

Number of people in your vehicle? _____ Were police notified? Yes No

Did head strike windshield or object? Yes No

Were you knocked unconscious? Yes No If so, for how long _____

You were struck from? Behind Front Left side Right side

You were? Driver Passenger Back seat

Were you wearing seat belt? Yes No Air bags deployed Car seat/booster

Did you feel pain immediately after the accident?

Yes No Latter 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 explain: _____

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? _____

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? Y N

Are your work activities restricted as a result of this accident? Yes No

Since the injury, are your symptoms Improving? Getting worse? The same?

