PREMIER CHIROPRACTIC

AUTO ACCIDENT QUESTIONNAIRE

Name: _____ Today's Date _____ Date of Accident _____

Where were you? ☐ driver ☐ passenger ☐ pedestrian

Struck from? ☐ behind ☐ right side ☐ left ☐ side ☐ front ☐ auto parked

Did your car strike the others involved? ☐ yes ☐ no

Did the other car strike yours? ☐ yes ☐ no

Accident Location _____ City _____

Road conditions at the time of the accident? ☐ wet ☐ dry ☐ icy ☐ other _____

Did the police come to the accident? ☐ yes ☐ no Do you have a copy of the report? ☐ yes ☐ no

Who was given a ticket? _____ Who was at fault? _____

Were you wearing a seat belt? ☐ yes ☐ no If so, Shoulder/Lap Belt _____ or Lap Belt _____

Did you know you were going to be hit before the accident? _____

Did you lose consciousness (black out) upon impact? ☐ yes ☐ no If so, estimate how long? _____

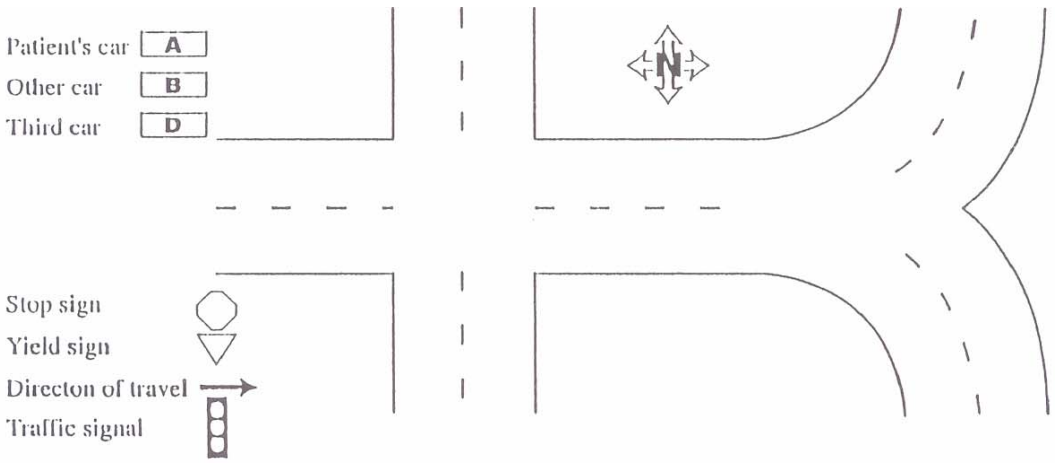
Were you taken to the hospital? ☐ yes ☐ no If so, were you taken by ambulance ? ☐ yes ☐ no

Have you seen any other medical facilities for your injuries? ☐ yes ☐ no If so, did they take x-rays ☐ yes ☐ no

If so, Where? _____ Dr. _____

Were you prescribed any medications? ☐ yes ☐ no If so, what _____

PLEASE DRAW A DIAGRAM OF THE ACCIDENT



PLEASE WRITE A DESCRIPTION OF THE ACCIDENT

_____

_____

_____

_____

_____

_____

_____

How far was the top of the headrest or seat back from the top of your head?
Approximately _____ inches (Circle One) Above Below

Was your head facing straight forward at the time of the impact? ☐ yes ☐ no

If no, what direction was it facing and how much? _____

PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ringing	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

CAR YOU WERE IN Who was:
Driver of the car you were in? _____ Registered Owner _____

Insurance company? _____ Phone No. _____

Claims Adjuster _____ Claim No. _____

Policy No. _____

Make _____ Model _____ Year _____

What is the estimated damages to the vehicle you were in? $_____

What parts of the vehicle were damaged _____

Was your vehicle stopped at the time of impact? ☐ yes ☐ no

If so, was the driver's foot on the brake? ☐ yes ☐ no

If no, estimate the speed of the vehicle you were in? _____ mph

If the vehicle was traveling was it: Slowing _____ Gaining Speed _____ Going at steady speed _____

OTHER VEHICLE Who was:
Driver of the other car? _____ Registered Owner _____

Insurance company of the other car? _____ Phone No. _____

Claims Adjuster _____ Claim No. _____

Policy No. _____

Make _____ Model _____ Year _____

What is the estimated damages to the other vehicle? $_____

What parts of the vehicle were damaged during the accident:_____

Was the other vehicle stopped at the time of impact? ☐ yes ☐ no

If no, estimate the speed of the other vehicle? _____ Mph

Do you have an attorney for this case? ☐ yes ☐ no

If so, Attorney's name _____

Address _____ Phone No. _____

- **Patient's Signature _____Date _____**