

ACCIDENT HISTORY QUESTIONNAIRE

Name: _____ Address: _____
City: _____ State: _____ Zip _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
Social Security _____ Driver's License Number: _____
Circle One: Married Single Widowed Divorced Separated
Business Employer: _____
Business Phone: _____ Type of Work: _____
Name of Spouse _____ Spouse's Social Security # _____
Spouse's Employer _____ Business Phone _____
Type of Work _____ Name and Ages of Children _____
Children at Home: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who Is Responsible For Your Bill, You and Spouse Auto Insurance Medicare
 Personal Health Insurance (Name) _____ Health Card # _____
Insured Person's Name _____ Date of Birth _____

PERSONAL INJURY PATIENT HISTORY

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car _____
Year & Model of the other car _____
7. What was the approximate damage done to your car? \$ _____
8. Visibility at time of accident: poor fair good other: _____
9. Road conditions at time of accident: icy rainy clear dark
 other (describe): _____
10. Where was your car struck?

FRONT



REAR

In your own words, please describe accident: _____

11. Type of Accident: Head-on collision Broad-side collision Front Impact
 Rear-end car in front Rear impact Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

13. Did you see the accident coming? yes no
14. Did you brace for impact? yes no

15. Were seatbelts worn? yes no
16. Were shoulder harnesses worn? yes no
17. Does your car have headrests? yes no
18. If yes, what was the position of those headrests compared to your head before the accident?
 Top of headrest even with bottom of head
 Top of headrest even with top of head
 Top of headrest even with middle of neck
19. Was your car braking? yes no
20. Was your car moving at the time of the accident? yes no
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
 Head turned left/right Body straight in sitting position
 Head looking back Body rotated right/left
 Head straight forward Other: _____
24. As a result of the accident you were: Rendered unconscious In shock Dazed, circumstances vague
 Other: _____
25. How was the shoulder harness adjusted? Loose Snug
26. Were you wearing a hat or glasses? yes no
27. Could you move all parts of your body? yes no
28. If no, what parts couldn't you move and why? _____

29. Were you able to get out of the car and walk unaided? yes no
30. If no, why not? _____
31. Did you get any bleeding cuts? yes no If yes, where? _____
32. Did you get any bruises? yes no If yes, where? _____
33. Please describe how you felt:
Immediately after the accident: _____
Later that day: _____
The next day: _____
34. Please list all symptoms you currently have that you feel are caused by the accident: _____

35. List any other symptoms or health conditions you had 6 months prior to the accident: _____

36. Have you missed time from work: yes no
37. If yes, full time off work: _____ to _____
38. If yes, part time off work: _____ to _____
39. Did you seek medical help immediately after the accident? yes no
40. If yes, how did you get there? Ambulance Police Someone else drove me Drove own car Other: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you tested HIV positive? Yes No

DRUGS YOU NOW TAKE:

- Nerve pills
- Pain killers/muscle relaxers
- Blood pressure medicine
- Insulin
- Other: _____

Please list any diseases you have had that were not mentioned above. _____

Other, describe _____

FEMALES ONLY

When was your last period? _____

Are you on oral contraceptives? Yes No

Are you pregnant? Yes No Not Sure

FAMILY HISTORY

Place an (X) if any family members has suffered from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Spinal Disorder |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Allergy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines |
| | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other, list: _____ |

41. Doctor #1: Name: _____
42. First Visit Date: _____
43. Were you examined? yes no
44. Were X-rays taken? yes no
45. Did you receive treatment? yes no Medications Braces Collars
46. If yes, what kind of treatment did you receive? _____
47. What benefits did you receive from the treatment? _____
48. Date of last treatment: _____
49. Doctor #2: Name: _____
50. First Visit Date: _____
51. Were you examined? yes no
52. Were X-rays taken? yes no
53. Did you receive treatment? yes no
54. If yes, what kind of treatment did you receive? _____
55. What benefits did you receive from the treatment? _____
56. Date of last treatment: _____
57. Do you have an attorney on this claim? yes no
58. If yes, who? _____
- Address _____
- City _____ State _____ Zip _____ Phone _____

Illustrate below how the accident happened.

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____

Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____