

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____
Patient _____ No. _____
Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Who referred you to our office? _____
Social Sec. # _____ Business Phone _____ Company Name _____
Company Address _____
Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____
Name of person who has made contact with you _____
Name of driver of vehicle in which you were injured (self or other) _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim 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 # _____
Give time and date present injury occurred _____ 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 Front seat Back seat Using seat belts Other protective devices
Did you feel pain immediately after the accident? Yes No Later that day Next day When _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was treatment given? _____
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? Yes No
Are your work activities restricted as a result of this accident? Yes No
Since the injury, are your symptoms Improving? Getting worse? The same?

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

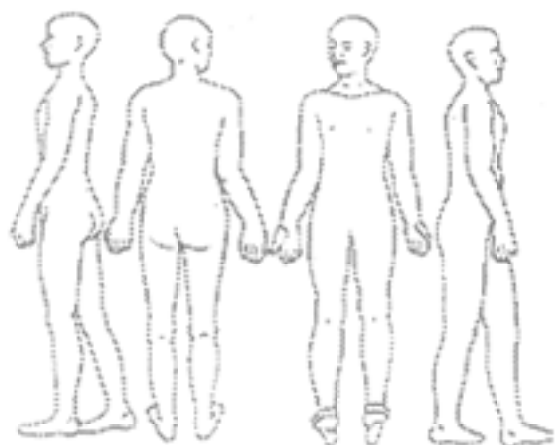
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



- P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____