

Automobile Accident Questionnaire

Accident Information

Name: _____ Date: _____

1. Date of Accident: _____ Time: _____ a.m./p.m.

2. Driver of car: _____ Where you were seated: _____

3. Owner of car: _____ Year and Model of car: _____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: head-on collision broad-side collision rear-end collision

front impact, rear-ended car in front non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? Yes No

11. Did you brace for impact? Yes No

12. Were you wearing a seatbelt? Yes No

13. Were you wearing a shoulder harness? Yes No

14. Does the car have headrests? Yes No

15. If yes, what was the position of your headrest? top of headrest even with bottom of head

top of headrest even with top of head top of headrest even with middle of head

16. Was your car braking? Yes No Was the other car braking? Yes No

17. Was your car moving at the time of the accident? Yes No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact?

head turned left/right body straight in sitting position head looking back

body rotated left/right head straight forward other: _____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

21. As a result of the accident were you: rendered unconscious dazed other: _____

22. Could you move all parts of your body? yes no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? yes no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? yes no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

How did you feel later that day night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent since the accident:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of smell | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> neck pain/stiffness |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> cold hands | <input type="checkbox"/> mid-back pain | <input type="checkbox"/> loss of memory |
| <input type="checkbox"/> cold feet | <input type="checkbox"/> low-back pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> tension | <input type="checkbox"/> constipation | <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> shortness of breath <input type="checkbox"/> |
| chest pain | <input type="checkbox"/> dizziness | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> fainting | <input type="checkbox"/> depression | <input type="checkbox"/> cold sweats | <input type="checkbox"/> anxious |
| <input type="checkbox"/> sleeping problems | <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes | |
| <input type="checkbox"/> ringing/buzzing in ears | <input type="checkbox"/> eyes sensitive to light | <input type="checkbox"/> other: _____ | |

27. Have you missed time from work? yes no Work hours are: full-time part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? yes no

29. Did you seek medical help immediately/soon after the accident? yes no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? yes no If yes, of what body part? _____

32. What treatments/prescriptions were given? bed rest brace adjustments medications

33. What benefit(s) did you receive from treatment(s)? _____

34. Date of last treatment: _____

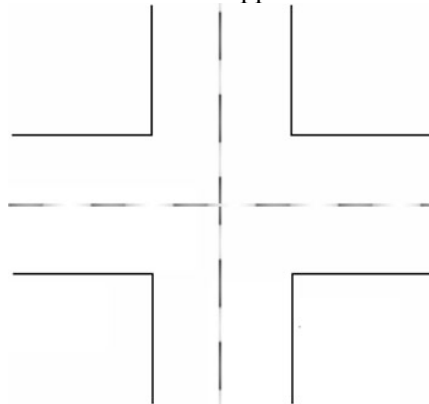
35. Are any of your activities of daily living any different now compared to before the accident?
 yes no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

37. Do you have an attorney handling this case? yes no

If yes, who? (name/address) _____

Insurance Information

Patient's personal insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____ Adjuster's name/phone: _____

Other party's insurance: _____

Insured's name (if other than patient) _____ Policy #: _____

Insurance Company Name: _____ Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____ Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____ City: _____ State/Zip: _____

Claim #: _____

Adjuster's name/phone: _____

Patient's Demographic Information

Patient's full name: Social Security #: _____

Address: _____

Date of Birth: _____

Mailing address (if different): _____

Phone: _____

Employer name: _____

Spouse's Occupation: _____

Employer's address: _____

Work phone: _____

Spouse's name: _____

Spouse's Social Security #: _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Portland Chiropractic Neurology** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **Portland Chiropractic Neurology** the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay **Portland Chiropractic Neurology** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____