Atlantic Coast Chiropractic Auto Accident Questionnaire

Patient Information *(please print)* *Date:*_____

Name_____ **SS#**_____

Address_____ **City**_____ **State**_____ **Zip**_____

❑**Male** ❑**Female** ❑**Married** ❑**Single** ❑**Widowed** ❑**Divorced** ❑**Separated**

Birth Date_____ **E-mail Address**_____
Home Phone_____ **Cell**_____ **Work**_____
Occupation/Student_____**Employer/School**_____
Emergency Contact_____ **Phone** _____**Relation**_____
Whom may we thank for referring you to us? _____
Name of local primary Physician_____ **May we contact them?**____
Primary Health Insurance _____
Secondary Health Insurance_____

Symptoms

Main Complaint_____ _____**When did it start?**_____
How Often? **Constant, frequent, intermittent, infrequent** **Getting better, worse, no change?**_____
What activity bothers it the most? _____
When is it at its best?_____ **When is it at its worst?**_____
Rate the pain - (0 is pain free - 10 is unbearable pain) **1 2 3 4 5 6 7 8 9 10**
Other Chiropractors?_____ **Positive Experience?**_____
Other type of physician/therapist?_____ **Positive Experience?**_____
Other Complaints_____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Previous Surgeries and Dates? _____
_____
List ALL Medications you are currently taking _____
_____

Women - How many children? _____ Pregnant? _____ Date of last Menstrual Cycle_____
Nursing? _____ Taking Birth Control Pills? _____

Accident Information-

Date Accident Occurred_____

Describe how the Accident took place: _____

_____

_____

_____

Were you the: □ Driver □ Front Passenger □ Back Passenger □ Pedestrian □ Bike
Automobile you were in: Year_____ Make_____ Model_____
Other Automobile: Year_____ Make_____ Model_____

Weather Condition: □ Sunny □ Dark □ Rainy □ Cloudy
Street Surface: □ Dry □ wet □ slick □ Icy □ Under Construction

Where did the Accident happen? Street_____ City/state _____
Was it at? □ A stop light □ stop sign □ while driving □ controlled/uncontrolled intersection
other:_____
Was the light: □ Green □ Red □ Yellow □ Flashing □ Turn Arrow

How fast were you going?_____MPH **The other vehicle?**_____MPH
Did you see the impact coming?_____ **Did you brace for impact?** _____
Type of impact: □ Rear end □ Front □ Side impact
Damage to your car: □ Front □ Rear □ Driver Side □ Passenger side □ Bumper □ Fender
Damage to other car: □ Front □ Rear □ Driver Side □ Passenger side □ Bumper □ Fender
Your Damage amount Estimate: $_____ **Other Vehicle: $**_____

Were you wearing a seatbelt? _____ Did air bags deploy?_____
On impact, your head was looking: □ Forward □ Behind □ Up □ Down □ Left □ Right
Did your body hit anything inside the car?_____ **What body part?**_____
What did it hit?_____ **Did you loose consciousness?**_____

Were you seen by the ambulance?_____ **Did they take you to the hospital?**_____
What hospital?_____ **Did they perform x-ray, MRI, CT?**_____
What was their diagnosis and treatment?_____

If no to the above, have you sought medical treatment?_____ **Explain?**_____
_____
How long after the accident did you seek care?_____

Since the accident have your pains gotten: □ Better □ Worse □ Remain unchanged
Have you ever had these problems in the past?_____
Are you suffering from any of the following? □ Headache □ Nausea □ Dizziness
□ Blurred vision □ Ringing in ears □Radiating arm or leg pains □ Loss of memory
□ Shortness of breath □ Bladder/Bowel problems
Explain:_____

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care and/or legal providers. I authorize and request the insurance company or attorney to pay directly to this office any payable benefits.

Patient Signature_____ **Date**_____