Automobile Accident Questionnaire

Please answer all questions completely

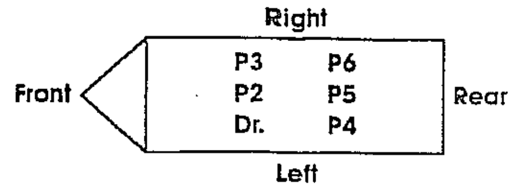
Name ______________________________ Date of Injury ______________

Time: ☐ Day ☐ Night ☐ Dawn ☐ Dusk   Road Cond.: ☐ Dry ☐ Damp ☐ Wet

Were You? ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Pedestrian ☐ Bicycle

TYPE OF ACCIDENT

☐ Head on collision ☐ Lt ☐ Rt ☐ Straight
☐ Rear end collision ☐ Lt ☐ Rt ☐ Straight
☐ Broadside collision ☐ From Lt ☐ From Rt
☐ Car hit dip in road, No collision
☐ Patient's car rear-ended in front
☐ Other



PATIENT'S HEAD DATA

☐ Head hit rear head rest ☐ Head hit by flying object
☐ Head hit ☐ Windshield ☐ Steering Wheel ☐ Roof ☐ Other

PATIENT DETAIL AT TIME OF CRASH IMPACT

☐ Seat belts fastened ☐ Shoulder belts fastened ☐ Airbag ☐ Braking
☐ Had pre-warning that accident was going to happen ☐ Bracing for impact
☐ Head Position: ☐ Lt ☐ Rt ☐ Straight ☐ Turned Around
☐ Hand Position: ☐ One on wheel ☐ Two on wheel ☐ ? Transmission: ☐ Manual ☐ Auto
☐ Sitting Position: ☐ Knees Lt. ☐ Knees Rt. ☐ Knees straight
☐ Other Injuries: ☐ Knee ☐ Leg ☐ Ankle ☐ Foot ☐ Hip ☐ Jaw
☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Bruises ☐ Contusions

Aware of impact collision: ☐ Y ☐ N   Felt body go: ☐ Fwd. then back ☐ Back then Fwd. ☐ ?

Did your body strike anything else in car? ☐ Y ☐ N ______________________

Did your vehicle strike other vehicle? ☐ Y ☐ N Was your car struck by another vehicle? ☐ Y ☐ N

Wearing glasses? ☐ Y ☐ N Still on? ☐ Y ☐ N Broken/Bent? ☐ Y ☐ N Ended up where? __________

Est. property damage? __________ ☐ Totaled ☐ Drivable ☐ Not Drivable Mirrors broken/bent? ☐ Y ☐ N

Police on scene? ☐ Y ☐ N Report made? ☐ Y ☐ N   Seat broken/bent? ☐ Y ☐ N

Were you knocked unconscious? ☐ Y ☐ N If so, how long? ______________

Initial symptoms: ☐ Headache ☐ Dizzy ☐ Disoriented ☐ Shock ☐ Neck pain/stiff ☐ Jaw Pain
☐ Back pain/stiff ☐ Numbness/Tingling ☐ 1st symptoms appeared __________ hrs./mins. after accident

After Accident: Taken by ______________ to ______________ Hospital ☐ Went home ☐ Other
☐ Went to ______________ Hospital later __________ (date/time) ☐ Went to Drs. Office __________

Had: ☐ X-rays ☐ Lab ☐ Meds ☐ Collar ☐ Other ☐ Follow-up instructions ☐ None

Was any other doctor consulted after your accident? ☐ Y ☐ N
If so, Doctor's name ______________________________

Did you return to work? ☐ Y ☐ N If not, date returned to work ______________

Are your work activities restricted as a result of this accident? ☐ Y ☐ N

Insurance Company:
Name ______________________________ Phone ______________
Address ______________________________
Policy and/or claim no. ______________________________

Other people in car? ☐ Y ☐ N
Name and phone number: ______________________________
Name and phone number: ______________________________
Name and phone number: ______________________________

Form 106-R/3-93   Signature: ______________________________

KENWOOD CHIROPRACTIC ARTS

AA / WC - HISTORY CONSULTATION

Name Date
Date of Injury When did your complaint(s) begin?
PLEASE check ALL PRESENT SYMPTOMS:

NECK: ☐weakness ☐pain ☐stiffness swelling ☐spasms ☐pain on motion ☐limited movement ☐surgery ☐ throat muscles swollen or sore.
WORSE: ☐after sleeping ☐during day ☐end of day

MID-BACK: ☐weakness ☐pain ☐spasms ☐rib pain.
WORSE: ☐after sleeping ☐during day ☐end of day

LOW BACK: ☐weakness ☐pain ☐ stiffness ☐swelling ☐surgery ☐ limited movement ☐pain on motion.
PAIN WHEN: ☐sitting walking ☐standing ☐sleeping.
PAIN IN: ☐sacro-iliac ☐tailbone ☐groin.
WORSE:☐ after sleeping ☐during day ☐end of day.

HEAD PAIN & HEADACHE: ☐side ☐front top ☐base of skull ☐band around head ☐hat-type pressure ☐throbbing head pain from neck ☐heavy head - ☐affects vision ☐produces nausea - incapacitating ☐handicaps normal function ☐migraine.

FACE: ☐pain ☐flushing ☐twitching.

JAW: ☐pain ☐clicking
WORSE: ☐when eating ☐sleeping

SHOULDER: local pain - radiates down arm - pain on movement - limited movement - pain from neck.
WORSE: after sleeping - during day - end of day.

ARMS: ☐local pain ☐radiating pain from neck ☐on movement ☐down arm during sleeping ☐end of day ☐ numbness ☐tingling ☐pins and needles.
FEELING LOSS: ☐elbow ☐wrist ☐ fingers ☐swelling ☐heaviness ☐cold hands ☐grip strength loss ☐can't raise ☐drop things.

HIPS, KNEES, LEGS: ☐local pain ☐radiating pain ☐from back ☐on movement ☐down leg ☐knee (front, back, side) ☐numbness ☐tingling ☐ feeling loss ☐knee swelling ☐ankle swelling ☐Charlie horses ☐cramps spasms ☐sciatica ☐varicose veins ☐heaviness.
PAIN ON: ☐sitting ☐prolonged standing ☐walking ☐shopping.

FEET: ☐swelling ☐discomfort ☐pain ☐pain on walking ☐pain with back problem ☐cold ☐numbness.

EYE, EAR, NOSE THROAT & MOUTH:
EYE: ☐pain ☐strain ☐red ☐light hurts ☐double vision ☐spots ☐glasses.
EAR: ☐ache ☐ringing in ears
NOSE: ☐bleeding
THROAT: ☐sore ☐painful ☐tightness problems with swallowing.
MOUTH: ☐bad taste ☐loss of taste.

FATIGUE: ☐must rest during day ☐ cannot get enough rest.
INTERMITTENT: ☐tiredness ☐fatigue ☐exhaustion.
CONSTANT: ☐tiredness ☐fatigue ☐exhaustion.
WALKING CAUSES: ☐tiredness ☐fatigue ☐exhaustion.

SLEEPING: ☐good ☐fair ☐poor ☐poor due to pain ☐requires excessive sleep.

NERVES: ☐burning ☐numbness ☐tingling ☐pins & needles ☐tremor ☐nervous tension ☐dizziness ☐poor equilibrium ☐loss of balance ☐loss of memory.

When your pain is at its worst, how does it interfere with your normal daily or work activities?

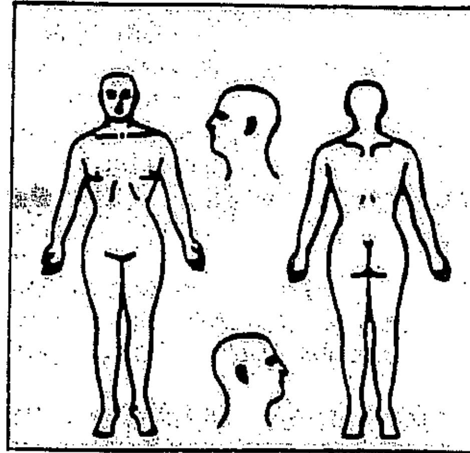
Previous chiropractic care? Yes☐No☐If yes, where?

Are you taking any medication?

List all previous surgery:

List all previous accidents:

CONSULTATION AND HISTORY
CLARIFICATION:
(DOCTOR USE ONLY)
PLEASE MARK YOUR AREAS OF PAIN
ON THE FIGURES BELOW



KENWOOD CHIROPRACTIC ARTS

APPLICATION FOR TREATMENT
(Confidential)

Date:____________________ Social Security No.:______________________________

Name:____________________________ Age:____ Birthdate:____________________

Home Address:______________________________ City/State/Zip:______________________

Home Phone:_______________ Work Phone:_______________ Cellular/Pager:______________
Text o.k. Y or N

E-mail:__________________________ Occupation: ______________________________

Employer's Name and Address: ____
____

Name of spouse or significant other: ____

Place of Employment: _____________________________________ Phone: ______________

Who may we thank for referring you to us? _______________________ Phone:______________

Who may we contact in case of emergency? _______________________ Phone:______________

Physician: ____ Phone:______________

Dentist: ____ Phone:______________

Nearest relative not living with you: ____________________________ Phone:______________

Nearest friend not living with you: _____________________________ Phone:______________

I have read and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Date:____________________ ____
Patient Signature

Date:____________________ ____
Parent or Guardian (if minor)

_____-____-______
Social Security Number