

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patients Name: _____

Today's Date: ____/____/____

Date of Accident: ____/____/____

Major Complaints or Symptoms:

*Describe complaints and rate them on a scale of 1-10 with 1 as the best

_____	Rating: _____	_____	Rating: _____
_____	Rating: _____	_____	Rating: _____
_____	Rating: _____	_____	Rating: _____
_____	Rating: _____	_____	Rating: _____

THE FOLLOWING QUESTIONS PERTAIN TO THE VEHICLE YOU WERE IN:

Your Position in the Vehicle:

- Driver
 - If driver, did you have your hands on the steering wheel? Yes No
- Passenger
 - Location:
 - Left Middle Right
 - Front Rear Third seat (rear)

Vehicle Size::

- Subcompact Full-size
- Compact Mini
- Mid-size Light
- Heavy Other: _____

Vehicle Type:

- Car Pick-up
- Van Truck
- Station Wagon Bus
- Other: _____

Speed of Your Vehicle:

- Stopped Moving Moderately
- Parked Moving Fast
- Slowing Moving at approx. ____mph
- Moving Slowly

Why Vehicle was Slowed or Stopped:

- Traffic Signal Parking
- Pedestrian Traffic
- Stop Sign Busy Intersection

Collision Type:

- Driver Side Impact Head on Collision Passenger Side Impact
- Rear Impact Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED:

Vehicle Size::

- Subcompact Full-size
- Compact Mini

Vehicle Type:

- Car Pick-up
- Van Truck

- | | | | |
|-----------------------------------|---------------------------------------|--|------------------------------|
| <input type="checkbox"/> Mid-size | <input type="checkbox"/> Light | <input type="checkbox"/> Station Wagon | <input type="checkbox"/> Bus |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | |

CONDITIONS AT THE TIME OF THE ACCIDENT:

- | | | | |
|--|---|------------------------------------|-------------------------------------|
| <u>Time of Day:</u> | <u>Road Conditions:</u> | <u>Visibility:</u> | <u>Visibility Compromised by:</u> |
| <input type="checkbox"/> Dawn | <input type="checkbox"/> Dry | <input type="checkbox"/> Excellent | <input type="checkbox"/> Brightness |
| <input type="checkbox"/> Full Daylight | <input type="checkbox"/> Damp | <input type="checkbox"/> Good | <input type="checkbox"/> Darkness |
| <input type="checkbox"/> Dusk | <input type="checkbox"/> Wet | <input type="checkbox"/> Fair | <input type="checkbox"/> Rain |
| <input type="checkbox"/> Night | <input type="checkbox"/> Snow Covered | <input type="checkbox"/> Poor | <input type="checkbox"/> Snow |
| | <input type="checkbox"/> Ice Covered | | <input type="checkbox"/> Fog |
| | <input type="checkbox"/> Patchy Ice/ Snow | | <input type="checkbox"/> Traffic |

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT:

- | | |
|--|---|
| <u>Where You...</u> | <u>Restraints: (Check all that apply)</u> |
| <input type="checkbox"/> Totally unaware that the accident was impending | <input type="checkbox"/> Seat Belt |
| <input type="checkbox"/> Aware that the accident was impending | <input type="checkbox"/> Shoulder harness |
| <input type="checkbox"/> Aware that the accident was impending and braced for it | <input type="checkbox"/> No Restraints |

If you were the Driver, was your foot on the brake peddle? Yes No Knocked off by impact

- | | |
|---|--|
| <u>Was the air bag deployed?</u> | <u>What Position was your headrest in?</u> |
| <input type="checkbox"/> Car not equipped with air bag(s) | <input type="checkbox"/> High Position |
| <input type="checkbox"/> Air bag(s) deployed | <input type="checkbox"/> Middle Position |
| <input type="checkbox"/> Air bag(s) not deployed | <input type="checkbox"/> Low position |
| <u>Position of Your head at time of impact?</u> | <u>Was Your head thrown...?</u> |
| <input type="checkbox"/> Facing straight ahead | <input type="checkbox"/> Backward and then forward |
| <input type="checkbox"/> Tilted forward | <input type="checkbox"/> Forward then backward |
| <input type="checkbox"/> Rotated to the left | <input type="checkbox"/> To the left <input type="checkbox"/> To the left then to the right |
| <input type="checkbox"/> Rotated to the right | <input type="checkbox"/> To the right <input type="checkbox"/> To the right then to the left |
| <u>Position of Your body at time of impact?</u> | <u>Was Your body thrown...?</u> |
| <input type="checkbox"/> Straight | <input type="checkbox"/> Backward and then forward |
| <input type="checkbox"/> Tilted Forward | <input type="checkbox"/> Forward then backward |
| <input type="checkbox"/> Rotated to the left | <input type="checkbox"/> To the left <input type="checkbox"/> To the left then the right |
| <input type="checkbox"/> Rotated to the right | <input type="checkbox"/> To the right <input type="checkbox"/> To the right then the left |
| | <input type="checkbox"/> Across the vehicle |
| | <input type="checkbox"/> Outside the vehicle |
| | <input type="checkbox"/> Under the vehicle |

- | | |
|---|---|
| <u>Damage to the vehicle You were in:</u> | <u>Citations:</u> |
| <input type="checkbox"/> Incurred minimal damage | <input type="checkbox"/> None issued |
| <input type="checkbox"/> Incurred moderate damage | <input type="checkbox"/> Yourself |
| <input type="checkbox"/> Incurred severe damage | <input type="checkbox"/> Driver of vehicle patient was a passenger of |

Was totaled

Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head:

- Steering Wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left Door
- Right Door
- Left Window
- Right Window
- Console
- Gear Shift
- Front Seat
- Back Seat

Left Arm:

- Steering Wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left Door
- Right Door
- Left Window
- Right Window
- Console
- Gear Shift
- Front Seat
- Back Seat

Right Arm:

- Steering Wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left Door
- Right Door
- Left Window
- Right Window
- Console
- Gear Shift
- Front Seat
- Back Seat

Torso:

- Steering Wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left Door
- Right Door
- Left Window
- Right Window
- Console
- Gear Shift
- Front Seat
- Back Seat

Left Leg:

- Steering Wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left Door
- Right Door
- Left Window
- Right Window
- Console
- Gear Shift
- Front Seat
- Back Seat

Right Leg:

- Steering Wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left Door
- Right Door
- Left Window
- Right Window
- Console
- Gear Shift
- Front Seat
- Back Seat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did You lose consciousness?

- Yes
- No

Immediately following the accident did you feel....?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were You able to walk unaided?

- Yes
- No

Where did You go...?

- Drove Home
- Was driven home
- Drove to Hospital
- Was driven to Hospital
- Was driven to School
- Drove to Work
- Was driven to work
- Drove to school

Next day discomfort...?

Did Your major complaints exist before the accident?

- Increased Decreased Yes, explain: _____
 Same No

In what areas did you IMMEDIATELY feel pain?

- Head Neck Upper Back Mid Back Ribs
 Chest Abdomen Low Back Pelvis
- Rt. Shoulder Lt. Shoulder Rt. Hip Lt. Hip
 Rt. Arm Lt. Arm Rt. Thigh Lt. Thigh
 Rt. Elbow Lt. Elbow Rt. Knee Lt. Knee
 Rt. Wrist Lt. Wrist Rt. Calf Lt. Calf
 Rt. Hand Lt. Hand Rt. Ankle Lt. Ankle
 Rt. Fingers Lt. Fingers Rt. Foot Lt. Foot
 Rt. Buttocks Lt. Buttocks Rt. Toes Lt. Toes

In what areas did you experience lacerations (cuts)?

- Head Neck Upper Back Mid Back Ribs
 Chest Abdomen Low Back Pelvis
- Rt. Shoulder Lt. Shoulder Rt. Hip Lt. Hip
 Rt. Arm Lt. Arm Rt. Thigh Lt. Thigh
 Rt. Elbow Lt. Elbow Rt. Knee Lt. Knee
 Rt. Wrist Lt. Wrist Rt. Calf Lt. Calf
 Rt. Hand Lt. Hand Rt. Ankle Lt. Ankle
 Rt. Fingers Lt. Fingers Rt. Foot Lt. Foot
 Rt. Buttocks Lt. Buttocks Rt. Toes Lt. Toes

At the Hospital, what areas were x-rayed?

- Head Neck Upper Back Mid Back Ribs
 Chest Abdomen Low Back Pelvis
- Rt. Shoulder Lt. Shoulder Rt. Hip Lt. Hip
 Rt. Arm Lt. Arm Rt. Thigh Lt. Thigh
 Rt. Elbow Lt. Elbow Rt. Knee Lt. Knee
 Rt. Wrist Lt. Wrist Rt. Calf Lt. Calf
 Rt. Hand Lt. Hand Rt. Ankle Lt. Ankle
 Rt. Fingers Lt. Fingers Rt. Foot Lt. Foot
 Rt. Buttocks Lt. Buttocks Rt. Toes Lt. Toes

Where did you experience pain on the day FOLLOWING the accident?

- Head Neck Upper Back Mid Back Ribs
 Chest Abdomen Low Back Pelvis
- Rt. Shoulder Lt. Shoulder Rt. Hip Lt. Hip
 Rt. Arm Lt. Arm Rt. Thigh Lt. Thigh
 Rt. Elbow Lt. Elbow Rt. Knee Lt. Knee
 Rt. Wrist Lt. Wrist Rt. Calf Lt. Calf
 Rt. Hand Lt. Hand Rt. Ankle Lt. Ankle

- | | | | |
|---------------------------------------|---------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Rt. Fingers | <input type="checkbox"/> Lt. Fingers | <input type="checkbox"/> Rt. Foot | <input type="checkbox"/> Lt. Foot |
| <input type="checkbox"/> Rt. Buttocks | <input type="checkbox"/> Lt. Buttocks | <input type="checkbox"/> Rt. Toes | <input type="checkbox"/> Lt. Toes |

Did You go to the Hospital?

- Yes No

Were You admitted to the Hospital?

- Yes No

-if yes, how long? _____

If You went to the Hospital, when...?

- At the time of accident
 Next day
 Other: _____

If You went to the Hospital, where...?

If You went to Hospital, what was the name of the Doctor that cared for You?

Dr. _____

What treatment was given?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Placed in cervical collar | <input type="checkbox"/> Bandaged | <input type="checkbox"/> Given pain medication |
| <input type="checkbox"/> X-rayed | <input type="checkbox"/> Given stitches | <input type="checkbox"/> Physical Therapy | |
| <input type="checkbox"/> Given instructions on concussions | | <input type="checkbox"/> Given info. Regarding strains and sprains | |
| <input type="checkbox"/> Instructed to call a Orthopedic Surgeon | | <input type="checkbox"/> Instructed to call a Private/General Physician | |
| <input type="checkbox"/> Referred to this office for treatment | | <input type="checkbox"/> Other: _____ | |

Have You seen any other Doctor(s) as a result of this accident?

- Yes No

-if yes, what was the Doctor's name? _____

**THE FOLLOWING AUTO ACCIDENT INFORMATION IS REQUIRED IN ORDER
TO CARE FOR YOU UNDER A PERSONAL INJURY CASE:**

YOUR AUTO INSURANCE INFORMATION:

Insurance Company _____
Address _____ City _____ State/Zip _____
Phone #: (_____) - ____ - ____.
Contact Person: _____

YOUR ATTORNEY INFORMATION:

Name _____
Address _____ City _____ State/Zip _____
Phone #: (_____) - ____ - ____.

CLAIM # _____

OTHER PERSON'S AUTO INSURANCE INFORMATION:

Insurance Company _____
Address _____ City _____ State/Zip _____
Phone #: (_____) - ____ - ____.
Contact Person: _____

Signature

Date

Assignment of Payment
And
Security Agreement for Medical Services

For good and valuable consideration, the undersigned directs you, my insurance company, and/or attorney, to pay directly to New Life Chiropractic Center, such sums as may be due and owing said office for services rendered to me, and to withhold such sums from any disability benefits, workers' compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgment, or verdict on my behalf as may be necessary to protect said office.

I hereby further give a lien to said office against any and all insurance benefits and proceeds of any settlement, judgment or verdict named herein, which may be paid to me as a result of the injuries or illnesses for which I have been treated by said office. The undersigned does hereby assign and set over to said New Life Chiropractic Center is entitled to payment for services rendered.

I understand that I remain personally responsible for the total amounts due to said office for their services, and I further understand and agree that this Assignment of Payment, Security Agreement for Medical Services, Lien, and Authorization does not constitute any consideration for the office to await payment, and they may demand payments from me immediately upon rendering services at their option.

Dated _____

X _____
Patient's Signature

Witnessed by me, a Notary Public of the State of Indiana, on the ____ day of _____,
20____.

X _____
Notary Public