WALKER CHIROPRACTIC

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ACCIDENT HISTORY QUESTIONNAIRE

Personal Injury Patient History *(All information you give is confidential)*

Name: _____ Today's Date: ____/____/____

Date of Accident: _____ Time: _____ ☐AM ☐PM

Type of Injury: ☐Work ☐Sport ☐Fall ☐Trauma ☐Car ☐Other: _____

What state did the accident occur in? _____

Driver of Car: _____ Who owns the car? _____

Who else was in your vehicle?

_____

Year and model of your car: _____ Year and model of other car: _____

Where were you seated? _____ Approximate damage to your car: $ _____

Visibility at the time of the accident: ☐Poor ☐Fair ☐Good

Road conditions at the time of the accident:

☐Icy ☐Rainy ☐Wet ☐Clear ☐Dark ☐Other: _____

Circle where the point of impact was

Front  Back

Type of accident: ☐Head on ☐Broad-side ☐Rear-end ☐Front impact

At the time of the accident, which parts of your body hit which parts on the inside of the vehicle?

_____

_____

_____

Did you see the accident coming? ☐Yes ☐No Did you brace for the impact? ☐Yes ☐No

Was seatbelt worn? ☐Yes ☐No Does your car have headrests? ☐Yes ☐No

Was your car moving at the time of the accident? ☐Yes ☐No If, yes how fast were you going? _____ MPH

Was anyone else present during your accident? ☐Yes ☐No

Did you report your accident to your insurance company? ☐Yes ☐No

If yes, what insurance company? _____

Adjusters Name: _____ Phone Number: _____

Claim Number: _____

Other Person's Insurance Company: _____

Adjusters Name: _____ Phone Number: _____

Claim Number: _____

Head/Body position at the time of impact:

☐Body straight in sitting position ☐Body rotated to left or right ☐Head straight forward

☐Head turned to the Left or Right ☐Head looking back ☐Other: _____

Has this type of accident happened to you before? ☐Yes ☐No If yes, when? _____

As a result of the accident, were you:

☐Rendered Unconscious ☐In shock ☐Dazed ☐Other: _____

Were you wearing a hat or glasses? ☐Yes ☐No Could you move all parts of your body? ☐Yes ☐No

If no, what parts couldn't you move and why?

_____

_____

_____

Were you able to get out of the car and walk unaided? ☐Yes ☐No

If no, why not? _____

Did you get bleeding cuts? ☐Yes ☐No If yes, where? _____

Did you get any bruises? ☐Yes ☐No If yes, where? _____

Describe how you felt: _____

Immediately after the accident:

_____

_____

Later that day:

_____

_____

The next day:

_____

_____

Now

_____

_____

Please indicate the symptoms that are a result of this accident:

☐Dizziness	☐Depression	☐Jaw Pain	☐Nausea
☐Memory Loss	☐Irritability	☐Arms/ Shoulder Pain	☐Back Pain
☐Headache(s)	☐Fatigue	☐Numbness/ Tingling	☐Blurred Vision
☐Ringing in Ears	☐Tension	☐Chest Pain	☐Leg Pain
☐Neck Pain	☐Shortness of Breath	☐Depression	☐Back Stiffness
☐Facial Pain	☐Neck Stiffness	☐Anxiety	☐Light Sensitivity
☐Mid Back Pain	☐Muscles Soreness	☐Loss of Balance	☐Muscle Spasms

☐Other: _____

Occupation: _____ Employer: _____

Describe duties: _____

Have you missed time from work? ☐Yes ☐No If yes, what days? _____

Have you been to any doctor and/or hospital as a result of the accident? ☐Yes ☐No

If yes, when did you go? ☐Immediately after the accident ☐The next day ☐+2 days

How did you get there? ☐Ambulance ☐Private transportation

Name of Hospital and/or attending doctor (1):

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Was MRI/CT taken? ☐ Yes ☐ No

Describe any treatment you received:

Name of Hospital and/or doctor (2):

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Was MRI/CT taken? ☐ Yes ☐ No

Describe any treatment you received:

Is your condition: ☐ Improving ☐ Worsening ☐ Staying the same ☐ Comes and goes

Briefly describe the events that occurred just before and during your accident:

In the box below please illustrate how the accident happened:

I, the undersigned, hereby agree that the above information is true and in no way fabricated. I understand that if any of my medical or account info has changed that I inform the front desk personnel. Please remember you are ultimately responsible for your account.

Patients signature and/or Legal Gaurdian: _____

Date: _____