Sheldon Road Chiropractic & Massage Therapy

AUTOMOBILE ACCIDENT QUESTIONAIRE

Name _____ Date:_____ SSN: ____-____-____ Age _____

Driver License #:_____

Insurance Company:_____ Claim #:_____

Claims Address:_____ Adjuster:_____

Have you retained an Attorney? □ YES □ NO Name & Address of attorney:_____

_____

GENERAL SYMPTOMS

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? □ YES □ NO. If yes, which part and how?_____

_____

Where were you taken after the accident?_____

Where you hospitalized? □ YES □ NO. If yes, for how long? _____

Did you receive care from any other health care specialist? □ YES □ NO. If yes, what is the specialist's name?_____

_____

What type of care where you given and for how long?_____

_____

Where did you feel the pain?_____

What are your current symptoms?_____

Have you ever been injured in a similar manner? □ YES □ NO. If yes, how When?_____

_____

ACCIDENT HISTORY

Date of Accident:_____ Time of Accident:_____ □ A.M. □ P.M.

State how the accident happened in your own words:_____

_____

_____

What type of vehicle were you in? Make: _____ Model:_____ Year:_____

Were you driving? □ YES □ NO. Was it your car? □ YES □ NO. If not, whose?_____

Passenger?_____Front?_____ Back?_____ Right Side:____ Left Side:_____ Were you rotated in your seat? □ YES □ NO.

Were you reclined? □ YES □ NO. Other:_____

Other people in car? □YES □ NO. Names and Addresses:_____

_____

Were they Injured? □ YES □ NO. If yes, explain:_____

_____

Seat belts on: □ YES □ NO. Shoulder harness on: □ YES □ NO. Position of Headrest:_____

Was it: □ Daylight □ Night □ Dusk □ Dawn. What were the weather conditions:_____

Were you tired? □ YES □ NO. Were you awake? □ YES □ NO. How long had you been in the car?_____

Where were you prior to the accident?_____

What were the traffic conditions?_____

What was the posted speed limit?_____ How fast were you going?_____ Type of road: □2Lane □4Lane □Gravel □Tar

Did it happen at a / an: □ Stop Sign □ Traffic Light □ Intersection □ Highway

Was your car hit? □ Front □ Back □ Left Side □ Right Side. What Damage was done to your car?

Inside:_____

Outside:_____

Other:_____

If you struck another car, did you strike it: □ Front □ Back □ Side. What was the damage to the other car?_____

Inside:_____

Other:_____

In what condition was the vehicle prior to the accident?_____

Do you have pictures of the involved automobile? □ YES □ NO. What type of vehicle was involved in the accident?

□ Car □ Truck □ Motorcycle □ Other;_____. Size and Type:_____

Was accident report made? □ YES □ NO. Police of: City:_____ Country:_____ State:_____

Who was ticketed?_____ For what?_____

Did your vehicle strike anything? □ YES □ NO. If yes, □ Another Car □ Sign □ Tree □ Bridge □ Hedge □ An Embankment

□ Other:_____ Size and Type:_____

Were you completely conscious after the impact? □ YES □ NO. Do you remember the impact? □ YES □ NO.

Did your vehicle go off the road? □ YES □ NO. If so, □ Into a ditch □ An Embankment . How Deep?_____

Does it bother you to ride in a car now? □ YES □ NO. If so, as a □ Driver □ Passenger

State any strange events that happened during or immediately after the accident:_____

_____

Have you had any time loss from work? □ YES □ NO. If yes, from_____ to _____

Have you had to have any outside help? □ YES □ NO. What type?_____

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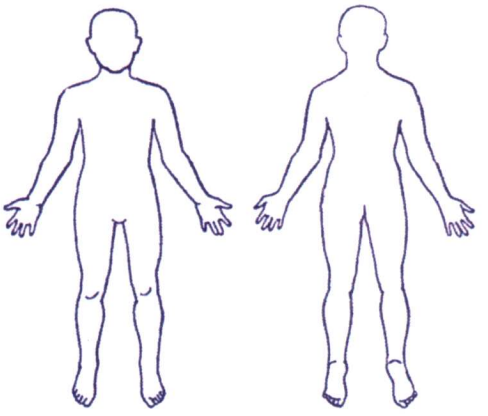
PLEASE DRAW THE ACCIDENT ABOVE.



MARK PAIN AREA
++++ Burning
0000 Stabbing
------ Sharp
/////// Constant

_____

Patient Signature Date Staff Signature