Automobile Accident Questionnaire

MOTOR VEHICLE CRASH INFORMATION

Name: _____ Date: _____

1. Date of Accident: _____ Time: _____ a.m./p.m.
2. Driver of car: _____ Where were you seated?: _____
3. Owner of car: _____ Year & Model of car: _____
4. Visibility at time of accident: Poor / Fair / Good / Other _____
5. Road conditions at time of accident: Ice / Rain / Wet / Clear / Dark / Other _____
6. Where was your car struck?: Right / Left / Rear / Front / Side / Other _____
7. Type of Accident Collision:

☐ Head-On ☐ Broad-Side ☐ Rear-End ☐ Front Impact/Rear-End vehicle in front ☐ Non-Collision

8. What part of the car was damaged?: _____
9. Describe what happened to you upon impact?: _____

_____

10. Did you see the accident was about to happen?: ☐ Yes ☐ No
11. Did you brace for impact?: ☐ Yes ☐ No
12. Were you wearing a seatbelt?: ☐ Yes ☐ No
13. Were you wearing a shoulder harness?: ☐ Yes ☐ No
14. Does the car have headrests?: ☐ Yes ☐ No
15. If Yes, what was the position of your headrest?: ☐ Top of headrest even with bottom of head

    ☐ Top of headrest even with top of head ☐ Top of headrest even with middle of head

16. Was your car braking?: ☐ Yes ☐ No
17. Was the other car braking?: ☐ Yes ☐ No
18. Was your car moving at the time of the accident?: ☐ Yes ☐ No
    a. If yes, how fast would you estimate you were going? _____
19. How fast would you estimate the other car was traveling?: _____
20. What was the position of your head and body at the time of impact?:

☐ Head turned Left/Right ☐ Head straight forward ☐ Head looking back

☐ Body rotated Left/Right ☐ Body in sitting position ☐ Other: _____

21. At the time of the accident, what parts of your head or body hit which parts of the vehicle?:

_____

_____

22. As a result of the accident were you: ☐ Unconscious ☐ Dazed ☐ Other _____

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

a. If No, why not?: _____

24. Could you move all parts of your body?: ☐ Yes ☐ No

a. If No, why not?: _____

25. Did you have any cuts or bruises from this accident?: ☐ Yes ☐ No

a. If Yes, where at?: _____

26. Describe how you felt immediately after the accident?: _____

_____

27. How did you feel later that ☐ Day ☐ Night?: _____

28. How did you feel the next day(s)?: _____

_____

29. Check all applicable symptoms apparent since the accident:

☐ Anxious	☐ Fainting	☐ Low-Back Pain
☐ Chest Pain	☐ Fatigue	☐ Mid-Back Pain
☐ Cold Hands	☐ Dizziness	☐ Neck Pain/Stiffness
☐ Cold Feet	☐ Eyes Sensitive to Light	☐ Nervousness
☐ Cold Sweats	☐ Headache	☐ Numbness in Fingers
☐ Constipation	☐ Irritability	☐ Numbness in Toes
☐ Depression	☐ Loss of Balance	☐ Ringing/Buzzing in Ears
☐ Diarrhea	☐ Loss of Memory	☐ Shortness of Breath
☐ Dizziness	☐ Loss of Smell	☐ Sleeping Problems
☐ Eyes Sensitive to Light	☐ Loss of Taste	☐ Tension

☐ Other: _____

30. Have you missed time from work?: ☐ Yes ☐ No

a. Work Hours are?: ☐ Full-Time ☐ Part-Time

b. If you missed time from work, how much time have you missed?: _____

31. Did the accident occur during your work hours?: ☐ Yes ☐ No

32. Did you seek medical help immediately/soon after the accident?: ☐ Yes ☐ No

a. If yes, how did you get there?: _____

b. Doctor/Hospital/Clinic Seen: _____ Date: _____

c. What was done?: _____

33. Were X-Rays taken?: ☐ Yes ☐ No

a. If yes, of what body part?: _____

34. What treatments/prescriptions/were given?: ☐ Bed Rest ☐ Brace ☐ Adjustments ☐ Medications

35. What Benefit(s) did you receive from treatment(s)?: _____

_____

36. Date of Last Treatment: _____

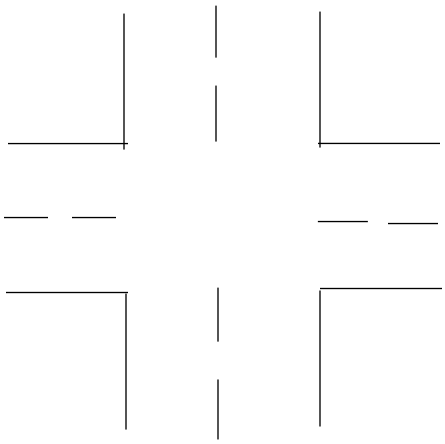
37. Are any of your daily activities any different now compared to before the accident?: ☐ Yes ☐ No

a. List anything you are unable to do: _____

b. List anything that is painful to do: _____

c. List anything that is difficult to do: _____

38. Indicate on the following diagram how the accident happened:



39. Comments: _____

_____

_____

_____

40. Do you have an attorney handling this case?: ☐ Yes ☐ No

a. If yes, who? (Name/Address): _____

_____

INSURANCE INFORMATION

Patient's Auto Insurance: _____

Insured's Name (If other than patient): _____

Policy #: _____

Phone #: _____

Address: _____

City: _____ State & Zip: _____

Claim #: _____

Adjuster's Name:_____Adjuster Phone #: _____

ASSIGNMENT OF PAYMENT

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Bull Run Chiropractic Clinic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Bull Run Chiropractic Clinic the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Bull Run Chiropractic Clinic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the attorney and/or insurance carrier refuses to pay my claim.

Patient's Signature: _____**Date:** _____

Patient's Name (Printed): _____

Witness Signature: _____**Date:** _____