SCHIERLING CHIROPRACTIC, LLC

AUTOMOMIBLE ACCIDENT QUESTIONARE

Today's Date: _____

Please be as specific as possible!

Name: _____ Date of Accident_____

Where did the accident occur? City: _____ State: _____

STREET / HWY: _____

What time of day did the accident occur? _____ AM PM

Describe the accident: Be as specific as possible!

Did your vehicle strike another vehicle? Yes No

Make, Model, and Year of your vehicle: _____

Make, Model, and Year of other vehicle: _____

What were road conditions? DRY WET ICY FOGGY GRAVEL OTHER_____

Were you aware the accident was going to happen or were you caught by surprise? AWARE SUPRISE

How much property damage did your vehicle sustain? Minimal Moderate Extensive Totaled

How much property damage did the other vehicle sustain? Minimal Moderate Extensive Totaled

At the time of impact, was your vehicle STOPPED MOVING If moving, estimate how fast (mph):_____

At time of impact, were you looking STRAIGHT AHEAD RIGHT LEFT

Did an airbag deploy? Yes No

Please describe _____

Was your vehicle an automatic or a standard transmission? AUTOMATIC STANDARD (gear shift)

Were you wearing a seat belt? Yes No Was your headrest? UP DOWN UNKNOWN

Did your vehicle flip over or roll over? Yes No

Were you hit from the: FRONT LEFT SIDE RIGHT SIDE REAR ENDED

Was there a second collision after the first collision? Yes No

If yes, please describe_____

Were you thrown out of your seat? Yes No _____

Were you thrown out of the vehicle? Yes No _____

What was your position in the vehicle?

Driver: If Driver were your hands on the steering wheel? Left hand Right hand Both

Passenger: If passenger, were you sitting in Front Right Rear Left Rear

Did you brace for impact? Yes No … I braced with my hands Ibraced with my feet

Which way were you facing or looking at the time of impact… straight ahead Left Right

Did you strike anything in the vehicle at the time of impact? Yes No

If yes, specify what part of your body struck what: For example: if your chest and shoulder hit the steering wheel, simply check "steering wheel" and write chest and shoulder next to it.

Steering Wheel _____ Dashboard _____

Windshield _____ Roof_____

Left Side Door _____ Right Side Door_____

Left Side Window. _____ Right Window _____

Other_____

Did the seat back bend / break down flat? Yes No

Did you lose consciousness? Yes No If yes, for how long?_____

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious nervous nauseous upset weak Other _____

Have you had any of these symptoms since then? Yes No If yes, please describe:_____

Have you been heat intolerant since the accident? Yes No

Has the accident affected your moods? Yes No If yes, please describe_____

Treatment and/or hospitalization:

Did you go to hospital? Yes No

Were you admitted to the hospital? Yes No If yes, how long was your stay? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital:_____ City/State:_____

Attended by Dr. _____

… what treatment was given?

None Placed in a cervical collar X-ray given Stitches Bandaged

Given pain or Other medication(s) Given instructions regarding concussions

Given instructions regarding sprains and strains Physical Therapy

Instructed to call a Orthopedic Surgeon Instructed to call a Private Physician

Were you referred to this office for treatment? Yes No Other _____

Have you seen any other doctor(s) as a result of this accident? Yes No

Doctor's name(s)_____

Are you still seeing a doctor as a result of this accident? Yes No If "yes" how often? _____

CHIEF Complaints or Symptoms:

Neck pain (check the areas the pain runs into from the neck)

□ none □ left shoulder □ left arm □ left forearm □ left hand □ right shoulder □ right arm

□ right forearm □ right hand □ headache □ Migraine Headache □ upper back pain

Ringing in Ears? □Yes □No LEFT RIGHT BOTH Ears

Blurry Vision? □Yes □No LEFT RIGHT BOTH Eyes

Wrist Pain? □Yes □No LEFT RIGHT BOTH Wrists

Jaw Pain? □Yes □No LEFT RIGHT BOTH Sides

□ Dizziness □ Nervousness □ fatigue □ anxiety □ depression □ excessive □ irritability

□ fear of driving in a car □ a loss of concentration □ jaw clenching □ grinding of teeth at night

□ nightmares difficulty sleeping at night □ Heat Intolerance

Low Back Pain: (select the areas of radiating pain, if any…)

None buttocks left buttock right buttock left thigh

right thigh left knee right knee left foot right foot

Hip Pain: Left Right Bilateral

Knee Pain: Left Right Bilateral

Foot Pain: Left Right Bilateral

Numbness and/or Tingling:

Left Hand Right Hand Left Upper Arm Right Upper Arm

Left Foot Right Foot Left Leg Right Leg

Additional Symptoms/ Complaints: Be as specific as possible!

Have you lost any time from work due to your injuries? □Yes □No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? □Yes □No

Description of previous Accident: _____

_____

_____

Description of injuries due to previous accident: _____

_____

Was/Is there any residual pain from the previous injury? □Yes □No

Were you having pain prior to your most recent accident? □Yes □No

MEDPAY INFORMATION:

Be aware that filing a MedPay claim does NOT raise your insurance rates. In order to file MedPay, we must have a copy of your Accident Report.

Has the accident been reported to your Auto Insurance Company? Yes No

Do you have a copy of the accident report? _____

Do you have medical payments coverage (MedPay) on your Auto Insurance plan? Yes No

Have you received any benefits from your Auto Insurance Company yet? Yes No

Insurance Carrier: _____ Phone: (_____)_____-_____

Name of Adjuster: _____

Name of Insured: _____ Policy #: _____ Claim #: _____

X_____ _____

Patient Signature Date

_____

Print Patient Name