Patient Name ___________________________________________ Today's Date _______________

# Automobile Accident Questionnaire

Date of accident: ________________________

Were you the…. ☐ Driver ☐ Passenger (If so, ☐ Front Seat ☐ Back Seat) ☐ Pedestrian

Who else was in the vehicle? _____________________________________________________________

Were you on the job at the time of the accident? ☐ Yes ☐ No

If yes, were you driving your vehicle or a company vehicle? _____________________________________

Location of Accident: Street: ______________________ City: _________________ State: _____________

Were the police notified? ☐ Yes ☐ No Was a ticket given? ☐ Yes ☐ No

Who received the ticket? ☐ No one ☐ The other driver ☐ I don't know

Make of vehicle ___________________ Model of vehicle ___________________ Year of vehicle___________

Did the airbag(s) engage? ☐ Yes ☐ No

Amount of damage done to vehicle: ☐ No damage ☐ Minimal (< $2,000 damage) ☐ Moderate (> $2,000 damage)

☐ Totaled, severe damage

If a total loss has occurred, what is the amount they determined the damage at? ________________________

What is the estimated value of your vehicle? ___________________________

What is the make and model of the other vehicle involved? __________________________________________

## History of Accident

☐ Stopped at red light or stop sign and rear ended.

☐ Another vehicle ran a stop sign or red light.

☐ Slowing down to make a stop or turn - rear ended.

☐ Spun around.

☐ Side swiped.

☐ Head on collision - other vehicle traveling in opposite direction.

☐ Did vehicle get hit into another vehicle or tree?

☐ Lost control of vehicle.

☐ Rolled over.

☐ "T-Boned".

☐ Other ________________________

Were you wearing seat belt / shoulder strap? ☐ Yes ☐ No Did the seatbelt and shoulder strap engage? ☐ Yes ☐ No

Did you strike any objects inside the car? ☐ Yes ☐ No

If yes, ☐ Steering column ☐ Rear view mirror ☐ Dash Board ☐ Seat Broke ☐ Windshield ☐ Cannot remember detail (dazed) ☐ Headrest ☐ Door Frame ☐ Jarred or thrown about ☐ Other________________________________

Which way was your head turned at the time of impact? ☐ Right ☐ Left ☐Straight

Were you leaning forward at the time of impact? ☐ Yes ☐ No

Was your body turned at the time of impact? ☐ Right ☐ Left ☐ Straight

Did you know you were going to be hit? ☐ Yes ☐No (If yes, did you brace yourself? ☐ Yes ☐ No)

What portion of your body did you strike? ☐ Head (Where in the vehicle? ☐ Steering column/ ☐ side window/ ☐ front window/ ☐ rear window (truck)/ ☐ headrest) ☐ Chest ☐ Face ☐ Knees ☐ Arms ☐ Other ________________

Were you rendered unconscious, cut, or bleeding? ☐ Yes ☐ No
(If cut, please explain where: _______________________________________________________)

Did you experience <u>immediate</u> pain? Please indicate:

☐ Headache (right / left) ☐ Neck pain (right / left)

☐ Mid back pain (right / left) ☐ Low back pain (right / left)

☐ Leg pain (right / left) ☐ Arm pain (right / left)

☐ Other ______________________________

After the accident, did you: ☐ Go Home ☐ Go about your business ☐ Go to the hospital

## Hospitalization

If taken to the hospital, how? ☐ Ambulance ☐ Drove myself ☐ Driven by a friend/relative ☐ Went home and later taken or drove to the hospital.
Name of Hospital: ______________________________________________________________

☐ Novant Health ☐ CMC ☐ Other __________________________

Were you seen in the emergency room? ☐ Yes ☐ No Were you admitted to the hospital? ☐ Yes ☐ No
If admitted, how long did you stay? ___________________________________________
Name of admitting or hospital physician: ___________________________________________

In the emergency room or hospital, what was done?

☐ Examination ☐ Stitches ☐ X-rays ☐ Physical Therapy ☐ Cervical Collar

☐ Complete Bed rest ☐ Prescription given ☐ Hot or cold therapy ☐ Referral to another doctor

☐Other: ____________________________________

After your release what did you do? ☐ Return home to bed ☐ Return to work ☐ Other ________________________________

When did you first consult a physician? ☐ Same day ☐ Following day ☐ Within a few days ☐ Other: _______________

****If you consulted this office first, skip to PAST HISTORY.****

Who did you consult? Dr. __________________________________________

☐ Family physician ☐ Chiropractor ☐ Orthopedist ☐ Osteopath ☐ Neurologist ☐Other _____________

What did the doctor do? ☐ Chiropractic manipulation ☐ Examination ☐ Injections ☐ X-rays ☐ Traction ☐ Prescriptions

☐ Physical Therapy ☐ Other: _____________ (If physical therapy was rendered, how long: _____________________________)

Where did you receive these treatments? ☐ Hospital ☐ At Primary Care Physician office
How long were you under the care of this physician? _________________________

Are you still under his/her care? ☐ Yes ☐ No Frequency or number of visits now: ______________________________________

Did the doctor refer you to or have you been to any other physicians? ☐ Yes ☐ No (Explain: ______________________________
____________________________________________________________________________________________________

Other pertinent information: ______________________________________________________________________________
____________________________________________________________________________________________________

## Past History

Have you ever been in a previous automobile accident? ☐ Yes ☐ No (If yes, please give dates and details: ___________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Do you have lasting symptoms or are you still being treated for that accident? ☐ Yes ☐ No (If yes, please explain: ___________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Have you ever been treated for neck or back problems by any other physicians prior to this current accident? ☐ Yes ☐ No
(If yes, please explain: _____________________________________________________________________________________________
______________________________________________________________________________________________________________

Have you enjoyed good health prior to this accident? ☐ Yes ☐ No (If no, explain: ________________________________________
______________________________________________________________________________________________________________

## Disability

Have you lost any time from work since the accident? ☐ Yes ☐No

How many days? ___________________________________________

Still off work? ☐ Yes ☐ No

Job Description: ____________________________________________

Any additional comments or details you feel would be helpful regarding this accident?

CHARLOTTE CHIROPRACTIC CENTER PLLC

Review of Symptoms: Please indicate any personal history **prior to your injury.**

## CONSTITUTIONAL SYMPTOMS
Good general health lately YES NO
Recent weight change YES NO
Fever YES NO
Fatigue YES NO
Headaches YES NO

## EYES
Eye disease or injury YES NO
Wear glasses/contacts YES NO
Blurred or double vision YES NO

## EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing YES NO
Earaches or drainage YES NO
Chronic sinus problems YES NO
Nose bleeds YES NO
Bleeding gums YES NO
Bad breath or bad taste YES NO
Sore throat or voice change YES NO
Swollen glands in neck YES NO

## CARDIOVASCULAR
Heart trouble YES NO
Chest pain/angina pectoris YES NO
Palpitation YES NO
Shortness of breath with walking or lying flat YES NO
Swelling of feet, ankles, or hands YES NO

## RESPIRATORY
Chronic/frequent coughs YES NO
Spitting up blood YES NO
Shortness of breath YES NO
Wheezing YES NO

## GASTROINTESTINAL
Loss of appetite YES NO
Change in bowels YES NO
Nausea or vomiting YES NO
Frequent diarrhea YES NO
Painful bowel movements or constipation YES NO
Rectal bleeding or blood in stool YES NO
Abdominal pain YES NO

## GENITOURINARY
Frequent urination YES NO
Burning or painful urination YES NO
Blood in urine YES NO
Change in force of strain when urinating YES NO
Incontinence or dribbling YES NO
Kidney stones YES NO
Sexual difficulty YES NO
Male – Testicle pain YES NO
Female – Pain with periods YES NO
Female – Irregular periods YES NO
Female – # pregnancies _______
Female – # miscarriages _______
Female – date of last pap smear _______

## MUSCULOSKELETAL
Joint pain YES NO
Joint stiffness or swelling YES NO
Weakness of muscles/joints YES NO
Muscle pain or cramps YES NO
Back pain YES NO
Cold extremities YES NO
Difficulty in walking YES NO

## INTEGUMENTARY (skin, breast)
Rash or itching YES NO
Change in skin color YES NO
Change in hair or nails YES NO
Varicose veins YES NO
Breast pain YES NO
Breast lump YES NO
Breast discharge YES NO

## NEUROLOGICAL
Frequent or recurring headaches YES NO
Light headed or dizzy YES NO
Convulsions or seizures YES NO
Numbness or tingling sensations YES NO
Tremors YES NO
Paralysis YES NO
Head injury YES NO

## PSYCHIATRIC
Memory loss or confusion YES NO
Nervousness YES NO
Depression YES NO
Insomnia YES NO

## ENDOCRINE
Glandular or hormone problem YES NO
Excessive thirst or urination YES NO
Heat or cold intolerance YES NO
Skin becoming dryer YES NO
Change in hat or glove size YES NO

## HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts YES NO
Bleeding or bruising tendency YES NO
Anemia YES NO
Phlebitis YES NO
Past transfusion YES NO
Enlarged glands YES NO

## ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotic YES NO
Morphine, Demerol or other narcotics YES NO
Aspirin or other pain remedies YES NO
Tetanus antitoxin or other serums YES NO
Iodine, methiolate or other antiseptics YES NO
Other drugs/medication:_______________
___________________________________
___________________________________
___________________________________
___________________________________
Known food allergies:_______________
___________________________________
___________________________________
___________________________________
Environmental allergies:_____________
___________________________________

## AUTHORIZATION AND RELEASE
To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Name: ______________________________ Signature of Patient/Guardian: ______________________________

**Date:** _______________

© 2016 Charlotte Chiropractic Center, PLLC