AUTO COLLISION QUESTIONNAIRE I

Patient_____Date_____

Please explain in detail how your accident happened: _____

_____

_____

_____

_____

_____

_____

State auto collision occurred in: □ KY □ OH Other_____

Driver of vehicle you were injured in: □ Self _____

Driver's Car Insurance:_____

Policy#_____Claim#_____

Name of person/adjustor who has contacted you:_____

Driver of vehicle that hit you: □ None _____

At Fault Car Insurance:_____

Policy#_____Claim#_____

Name of person/adjustor who has contacted you:_____

Have you retained an attorney? □ No □ Yes □ Not Yet

If so, name, address & phone_____

Date and time of accident:_____□ am □ pm # of people in your vehicle:_____

Were you the: □ Driver □ Front Passenger □ Rear Passenger Other_____

Were the police notified? □ Yes □ No Was there a police report filed? □ Yes □ No

Did <u>your</u> vehicle <u>strike</u> another vehicle involved? □ Yes □No Other_____

Did <u>other</u> vehicle(s) <u>strike</u> your vehicle? □ Yes □No Other_____

Impact to your vehicle was on: □ Front □ Rear □ Driver Side □ Passenger Side □ Rooftop

□ Front Right corner □ Front Left corner □ Rear Right corner □ Rear Left Corner

Compared to my vehicle, the other vehicle was: □ Bigger □ Smaller □ Same size

The collision moved my vehicle: □ A little □ More than a little □ A lot

The amount of damage to my vehicle was: □ A little □ More than a little □ A lot

Road conditions were: □ Dry □ Wet □ Ice/snow □ Dirt □ Gravel □ Other_____

Did airbag employ? □ Yes □ No Were you injured by the airbag? □ Yes □ No

Did head strike windshield or object? □ Yes □ No Were you knocked unconscious? □ No □ Yes, how long _____

Direction you were looking when accident occurred? □ Straight ahead □ Down □ Up □ Turned Right □ Turned Left

Other_____

Top of headrest was located**…** □Above □Center □Below □Unknown **…** to top of your head.

The distance between my head & the headrest was: □ less than 1 inch □ 1-2 inches □ greater than 2 inches □ Unknown

My seat was: □ Not tilted back □ Tilted back a little □ Tilted back more than a little

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AUTO COLLISION QUESTIONNAIRE II

Patient_____Date_____

Type of restraints used? □ Shoulder & lap □ Lap only □ None used

Were bruises or injuries received as a result of the seat belt? □ Yes □ No

Location: □ Stomach □ Breast □ Shoulder Other_____

Were you surprised by the accident? □ Yes □ No

At the time of the collision my body hit: □ Nothing □ Windshield □ Steering wheel □ Ceiling □ Door

□ Dashboard □ Another body Other_____

Articles inside the vehicle that moved because of the collision: □ Nothing □ Glasses □ Drink □Purse □Papers

Other_____

At the time of the collision this part of my body struck something: □ Head □ Lt shoulder □ Rt shoulder □ Lt arm/hand

□ Rt arm/hand □ Lt hip/leg □ Rt hip/leg □ Lt knee □ Rt knee □ Lt foot □ Rt foot

Other _____

At the time of the collision my hands were on: □ Steering wheel □ Stickshift Other_____

At the time of collision my feet were on the: □ Break □ Gas □ Clutch □ Floor Other_____

Did you feel pain immediately after the collision? □ Yes □No, □Later that day □ Next day Other_____

Where did you feel pain immediately after collision?_____

Where were you taken after accident?_____

Was any Doctor consulted after accident? □ No □ Yes, Dr._____

Doctor's diagnosis:_____

Treatment given:_____

How often did you see the doctor? (1 time, 2X/wk, etc.)_____

How long did you see the doctor? (# days, weeks or months)_____

Have you ever had any complaints to involved area before? □ No □ Yes, what were the complaints _____

_____

Because of this automobile collision I have seen: □ No one □ ER □ Medical Doctor □ Another Chiropractor

□ Physical Therapist □ Massage Therapist Other_____

Because of this accident I am: □ Taking medication □ Taking NO medication

Were there any broken bones as a result of this accident? □ Yes □ No

If yes, what_____

Have you lost any days from work due to this accident? □ Yes □ No

If yes, list dates_____

Before this injury, were you capable of working on an equal basis with others your age? □ Yes □No

Are your work activities restricted as a result of this accident? □ No □ Yes, list_____

Have you had any accidents or trauma since this automobile collision? □ Yes □No

If yes, list_____

Since this injury, your symptoms have: □ Improved □ Gotten Worse □ Remained the Same

Patient Signature_____Date_____

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