Automobile Injury Questionnaire

Name_____Date_____Date of crash_____

Have you ever been treated by a chiropractor? Yes No

If yes for what condition?_____

Have you ever experienced similar symptoms? Yes No

If yes please explain_____

Accident History

Was the accident on the job? Yes No

You were: _____Driver _____Front seat passenger _____Rear seat passenger _____Motorcycle operator

_____Motorcycle passenger _____Pedestrian

Vehicle driven by_____

Your vehicle: _____Full-size SUV _____Midsize SUV _____Large car _____ Midsize car _____ Small car

Other vehicle: _____Full-size SUV _____Midsize SUV _____Large car _____ Midsize car _____ Small car

Road conditions: _____Wet _____Dry _____Snow/Ice

Head restraint: _____None _____Up _____ Down _____ Don't know

Was the seat broken? _____Yes _____No

Lap belt? _____ Wearing _____Not wearing _____Don't know

Shoulder belt? _____ Wearing _____Not wearing _____Don't know

Did airbag deploy? _____Yes _____No

Body position? _____ Good _____ Foreward lean Other: _____

Head position? _____Forward _____Left _____Right _____Up _____Down

Hands on steering wheel: _____Two _____ One _____N/A

Were you aware of the impending crash? _____Yes _____No

Did you strike anything on the interior of the vehicle? _____Yes _____No

Explain:_____

_____

_____

Describe the accident and draw a diagram to the right:

Diagram the accident

Describe: _____

_____

_____

_____

_____

_____

_____

Were you wearing a hat or glasses at the time of the crash?
_____Yes _____No

Were ether knocked off during the crash? ___Yes ___ No

Did you lose consciousness? _____Yes _____ No

Property damage to your vehicle? _____Major _____Moderate _____Minimal _____None

What symptoms have you had since the crash?
_____Headaches _____ Dizziness _____ Nausea _____Confusion/Disorientation
_____Neck Pain _____ Low back pain _____ Mid back pain _____Numbness
_____Arm/hand pain _____Leg/foot pain

Did you have symptoms immediately following the crash? _____ Yes _____No

How long after the crash did your symptoms begin?_____

Were you taken to the hospital in an ambulance from the crash site? _____ Yes _____ No

Emergency Room

Have you gone to the ER? _____Yes _____No Date:_____

Were X-rays/CT/ MRI taken? _____Yes _____ No **What body areas?** _____

Was blood drawn? _____Yes _____No

Was medication given/prescribed? _____Yes _____No

List:_____

Were follow up instructions given? _____ Yes _____No

List:_____

_____

_____

Treatment Since Accident

Have you received any type of treatment or gone to any providers since the accident occurred? ____ Yes ___ No

Described all treatment with approximate dates and how many times visited:

1._____

2._____

Have any of the treatments you received helped? _____Yes _____No

List the ones that have helped:
1._____

2._____

Did a doctor refer you for the treatments you have received? _____Yes _____No

Doctors name: _____

At this time how do you feel since the accident occurred?

____A lot better ____Moderately better _____Slightly better ____Same ____Moderately worse ____Slightly worse _____Much worse

Is there any other information you would like to provide?

_____

_____

_____

_____

_____

_____