

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

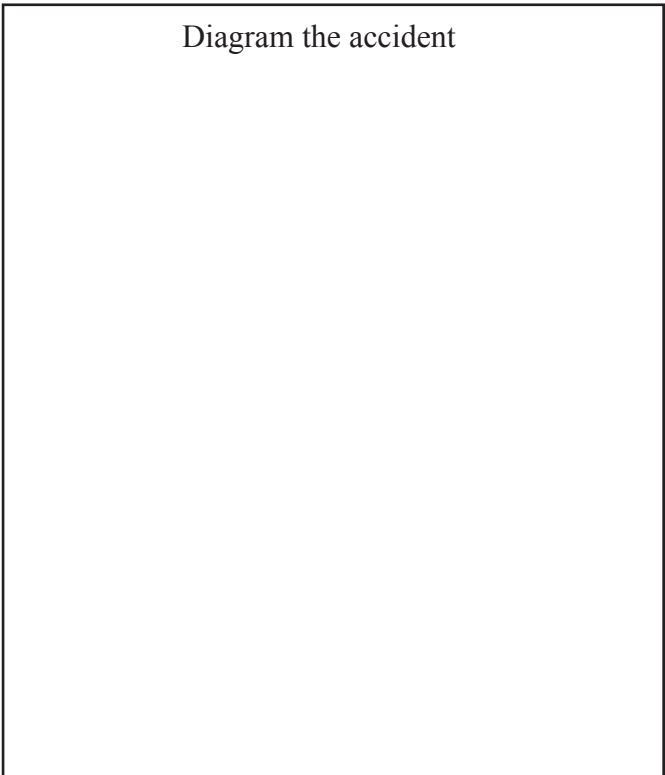
Were you aware of the impending crash? _____ Yes _____ No

Did you strike anything on the interior of the vehicle? _____ Yes _____ No

Explain: _____

Describe the accident and draw a diagram to the right:

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?
