

NATURAL HEALTH CENTER, P.C.
AUTO ACCIDENT QUESTIONNAIRE

Dear Patient:

We need this confidential information answered completely to help us assess your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

GENERAL INFORMATION:

NAME: _____ DATE OF BIRTH _____ SS# _____

NATURE OF AUTO ACCIDENT – Please explain in detail how your accident happened:

1. What was the time and date of this present injury? _____ AM ___ PM _____, 2000
2. City: _____ State: _____
3. Please explain in detail how your accident happened. (Please include location and Conditions.) _____

You were heading North East South West on _____ (street or highway)
Other vehicle was headed North East South West on _____ (street or highway)
Were police notified? Yes No - You were struck from Behind Front Left Side Right Side
You were Driver Passenger Front Seat Back Seat Using Seat Belts Other Protective Devices

4. Did you come in contact with any objects? _____ If yes, what objects (e.g., door, steering wheel, etc.)?

5. What parts of your body came in contact with the above object(s)? _____
6. Where did you feel pain or unusual feeling immediately after the accident? _____

7. Were you unconscious as a result of the injury? _____ If yes, how long? _____
8. Were you bleeding as a result of the injury? _____
9. Were you taken to the hospital after the accident? _____ By Ambulance? _____ If so, where? _____
Treating Doctor's name: _____ DC ___ MD ___ DO ___ DDS
10. Describe the doctor's diagnosis:----- _____
11. What treatment did you receive? _____
12. Are you still under a doctor's care? _____ If yes, please explain: _____

Past History:

1. Have you ever injured this area before? _____ If yes, when? _____
2. If injured before, did you lose time from work? _____
3. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? _____ If yes, please explain dates and details? _____

(continued on Back)

4. Have you been treated previously by a chiropractor? ____ If yes, please explain? _____

Present Information/Disability:

1. Did you lose any time from work? _____ If yes, date of lost time: _____

2. Have you returned to work? ____ If yes, date returned to work? _____

3. Job description: _____

4. Are your work activities restricted as a result of this accident? _____

5. Do you have to favor any part of your body in your work? ____ If yes, please explain? _____

6. Since this injury, are your symptoms: improving _____, getting worse _____, or the same? _____

Please explain? _____

7. Do any diseases or accidents affect your employment? _____ If yes, please explain? _____

Insurance Information:

Your Insurance Information

1. NAME OF DRIVER OF VEHICLE **IN WHICH** YOU WERE INJURED. (IF APPLICABLE) _____

INSURANCE CO.: _____ AGENT'S NAME, & PHONE _____

POLICY #: _____ CLAIM #: _____

OTHER CARS INSURANCE:

2. NAME OF DRIVER OF OTHER VEHICLE (IF ANY): _____

INSURANCE CO.: _____ PHONE #: _____

POLICY HOLDER: _____ POLICY # _____

CLAIM #: _____ ADJUSTER: _____

LEGAL REPRESENTATION:

1. Have you retained an attorney? _____ If yes, Name _____

Address _____ Phone#: _____

I verify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature

Date

Doctor's Signature (Upon review)

Date