FRYEBURG CHIROPRACTIC & WELLNESS CENTER

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be a neat and accurate as possible while completing this form. Thank you.

Name_____ Sex____ Marital Status _____ Date of Birth _____ Home Phone _____

Address_____ City _____ State_____ Zip_____

Occupation_____ Who referred you to our office?_____

(Indicate if child, student, housewife, unemployed, retired)

Social Sec.#_____ Business Phone_____ Company Name_____ Location_____

Spouse's First Name _____ Spouse's SSN_____ Spouse's Employer_____ Location_____

Please explain in detail how your accident occurred:

Insurance Co._____ Policy No._____ Claim No._____

Address_____ City_____ State_____ Zip_____

Driver of other vehicle (if any) Name_____ Insurance Company_____ Policy No._____

Driver of vehicle in which you were injured (if applicable)

Name _____Ins Co _____ Policy No._____

Name of your insurance adjuster _____

Have you retained an attorney? YES NO Name/address_____

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 Were you knocked unconscious? YES NO how long? _____

You were struck from Behind Front Left side Right side (circle one)

You were Driver Passenger Front seat Back seat Wearing seat belt Other protective devices (circle one)

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given?_____

Was any other doctor consulted after your accident? YES NO (circle one)

Is so, what was the doctor's name? _____ D.C. M.D. D.O. D.D.S

What was the diagnosis? _____ What treatment was given? _____

How often did you see the doctor? _____

Have you ever had any complaints in the involved area before? YES NO (circle one)

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? YES NO (circle one)

Are your work activities restricted as a result of this accident? YES NO (circle one)

Since this injury are your symptoms Improving? Getting worse? Same? (circle one)

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