Accident/Injury Questionnaire

Name: _____ Today's Date: _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

Was anyone else in the vehicle with you? □ No □ Yes – (# of people) _____

You were? □ ax - Front Seat – *Driver/Passenger* □ Rear Seat – *Behind Driver/Middle/ Behind Passenger/ 2nd Row/3rd Row*

Name of driver, *if not self:* _____ Name of Driver of other vehicle: _____

Did airbags deploy? □ No □ Yes Did the Police arrive? □ No □ Yes Using seatbelt? □ No □ Yes

Did you strike the windshield or object in car? □ No □ Yes (describe) _____

Were you knocked unconscious? □ No □ Yes (how long) _____

Where was your vehicle impacted? (circle one) Front / Rear / Passenger Side / Driver's Side / Other: _____

Your Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____

- Address: _____ City: _____ State: ____ Zip: _____

Other's Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____

- Address: _____ City: _____ State: ____ Zip: _____

WORKERS COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ Occupation: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Phone: _____ Email: _____

GENERAL ACCIDENT/INJURY INFORMATION – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Date of Accident: ____/____/_____ Time: ___: _____ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- Have you ever had any complaints in the involved area before? No Yes
  - If yes - Were they present at the time of the accident/injury? No Yes
  - If yes - Summarize these complaints prior to the accident: _____
- Were you capable of performing all of your work activities without restriction? No Yes

At the time of the accident/injury:

- Did you feel pain immediately after the accident? No Yes Later that day Next day When? _____
- Were you taken anywhere after the accident? No Yes Later that day Next day When? _____
  - If yes, How? _____ Where? _____
  - If yes, did you receive treatment? No Yes - (Describe) _____

Since the accident/injury:

- Are your symptoms: Improving? Getting Worse? The Same?
- Are your work activities restricted as a result of this accident/injury? No Yes - (How?) _____
- Have you missed any work since this accident? No Yes - (Dates?) _____
- Have you retained an Attorney? No Yes - Name: _____ Phone: _____

o Address: _____ City: _____ State: _____ Zip: _____

Collective Chiropractic

Patient No: _____