Marconi Chiropractic and Wellness 1002 MLK Jr Way Tacoma, WA 98405 253-750-3381

Auto Accident Questionnaire

Name _____ Today's Date _____

Date of accident _____ Time of accident _____ AM / PM

Location of accident _____

Name of driver of your vehicle _____

Type of vehicle you were in _____

Name of the other driver _____

Type of other vehicle(s) involved _____

Other driver's insurance company _____

- Where were you seated? _____
- Type of accident: □ head-on collision □ broad-side collision □ rear-end collision
  □ front impact, rear-ended car in front □ non-collision/other (describe):

_____

- Describe what happened to you upon impact:

_____

- Did you brace for impact? Yes / No
- Were seatbelts worn? Yes / No
- Was the vehicle braking? Yes / No
- Did airbags deploy? Yes / No
- Does your car have head rests? Yes / No
- Position of headrests (if any) compared to your head before the accident:

  □ top of headrest even with top of head □ top of headrest even with bottom of head

  □ top of headrest even with middle of neck
- Head/body position at the time of impact:

  □ head turned left / right □ head looking back □ body straight in sitting position

  □ body rotated left / right □ head straight forward □ other (describe):

_____

- Did any parts of your head / body hit the inside of the vehicle?

_____

- As a result of the accident, were you: □ rendered unconscious □ dazed (circumstances vague)

  □ other (describe): _____
- Could you move all parts of your body? Yes / No
- Were you able to get out of the car and walk unaided? Yes / No
- Any bleeding, cuts or abrasions from the accident? _____
- Any bruises from the accident? _____
- BEFORE the accident, did you have any physical complaints? Yes / No If yes, describe:

_____

- Describe how you felt immediately after the accident. Please be specific: _____

_____

- Describe how you felt later that □ Day □ Night _____

_____

- Describe how you felt the next □ Day □ Days _____

_____

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Patient Name: _____ **Date:** _____

Check symptoms apparent SINCE the accident:

☐ headache	☐ loss of memory	☐ nervousness
☐ neck pain/stiffness	☐ fatigue	☐ ringing/buzzing ears
☐ mid-back pain	☐ tension	☐ cold hands
☐ low back pain	☐ pain behind eyes	☐ cold feet
☐ eyes sensitive to light	☐ cold sweats	☐ diarrhea
☐ constipation	☐ numbness in toes	☐ chest pain
☐ depression	☐ numbness in fingers	☐ fainting
☐ sleeping problems	☐ loss of balance	☐ irritability
☐ loss of smell	☐ shortness of breath	☐ anxious
☐ loss of taste	☐ dizziness	☐ other _____

• Occupation _____ Employer _____

• Have you missed time from work? Yes / No If yes, indicate:

full-time off work _____ to _____ ; _____ to _____

part-time off work _____ to _____ ; _____ to _____

☐ **unable to work since accident**

Did you seek medical help immediately / soon after the accident? Yes / No

If yes, how did you get there? ☐ Someone drove me ☐ drove my own car

☐ ambulance ☐ police ☐ other _____

Doctor/Hospital/Clinic seen: _____ Date: _____

Were you examined? Yes / No

Were x-rays taken? Yes / No If yes, what parts of the body? _____

What treatment was given?

☐ bed rest ☐ brace ☐ physical therapy ☐ medication _____

☐ adjustments ☐ other _____

What benefits (if any) did you receive from treatment? _____

Date of last treatment _____

Have you sought/had any treatment from other than the doctor listed above? Yes / No

If yes, describe _____