## Atlantic Coast Chiropractic Auto Accident Questionnaire

	ormation (	please print)	Dat	e:	
Name		S	S#		
Address		City	State	eZip_	
<b>DMale DFem</b>	ale DM	arried <b>Single</b>	□Widowed	Divorced	□Separated
Birth Date	E-ma	uil Address			
Home Phone		Cell		Work	
Occupation/Str	ıdent	CellEmp Phone2	plover/School		
Emergency Cor	ntact	Phone	R	elation	
Whom may we	thank for refer	rring you to us?			
Name of local n	rimary Physici	rring you to us? ian		May we conta	oct them?
Primary Health	n Insurance				
Secondary Hea	lth Insurance_				
Commetore					
Symptoms					
Main Complain	t		When did	l it start?	
Main Complain How Often? Con	tstant, frequent, inte	ermittent, infrequent 🤇	Getting better.	worse, no cha	ange?
Main Complain How Often? Con	tstant, frequent, inte	ermittent, infrequent 🤇	Getting better.	worse, no cha	ange?
Main Complain How Often? Con	tstant, frequent, inte	ermittent, infrequent 🤇	Getting better.	worse, no cha	ange?
Main Complain How Often? Con What activity b When is it at its Rate the pain - (	it istant, frequent, into others it the m best? (0 is pain free ·	ermittent, infrequent ( ost? Wh Wh - 10 is unbearable	Getting better, en is it at its w pain) 1 2	worse, no ch: orst? 3 4 5 6 7	ange?  8 9 10
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Main Complain How Often? Con What activity be When is it at its Rate the pain - ( Other Chiropra Other type of pl Other Complain <b>Health His</b> AIDS/ HIV Aller Breast Lump Bror	itistant, frequent, into others it the m s best? (0 is pain free ctors? hysician/theray nts story - Plea rgy Shots Anemia Bulimia	ermittent, infrequent ost? Wh - 10 is unbearable P pist? <i>ese circle all that c</i> Anorexia Cancer	Getting better, en is it at its wo pain) 1 2 ositive Experio Positive Ex pply Appendicitis Art Cataracts Chi	worse, no cha orst? 3 4 5 6 7 ence? perience?	ange? 8 9 10  a Bleeding piabetes
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Main Complain How Often? Con What activity be When is it at its Rate the pain - ( Other Chiropra Other type of pl Other Complain <b>Health Hi</b> Breast Lump Bror Emphysema Epid Hepatitis Herr Migraines Misc	itistant, frequent, into others it the m s best? (o is pain free - actors? hysician/theray nts story - Plea rgy Shots nchitis Bulimia epsy Fractures nia Herniate sarriage Mono	ermittent, infrequent ost?Wh - 10 is unbearable P pist?P ase circle all that c S Glaucoma d disc Herpes N.S.	Getting better, en is it at its wo pain) 1 2 ositive Experie Positive Ex positive Ex positive Ex modeling for the set of the se	worse, no cha orst? 3 4 5 6 7 ence? perience? hritis Asthm cken pox Depres oorrhea Gout ney dx Liver d coporosis Parkin	ange? 8 9 10 8 9 10  a Bleeding ssion Diabetes Heart dx Kx Measles
Main Complain How Often? Con What activity by When is it at its Rate the pain - ( Other Chiropra Other type of pl Other Complain <b>Health His</b> AIDS/ HIV Aller Breast Lump Bror Emphysema Epid Hepatitis Herr Migraines Miso Pacemaker Pnet	itistant, frequent, into others it the m s best? (o is pain free ctors? hysician/theraj nts story - Plea sulimia phitis Bulimia phia Herniate	ermittent, infrequent ost? Wh - 10 is unbearable P pist? P pist? use circle all that c  Glaucoma d disc Herpes	Getting better, en is it at its wo pain) 1 2 ositive Experie Positive Ex positive Ex positive Ex modeling for the set of the se	worse, no cha orst? 3 4 5 6 7 ence? perience? perience? perience? perience? perience? orrhea Gout coporosis Parkin sumatoid Stroke	ange? 8 9 10 8 9 10 

## Previous Surgeries and Dates? \_\_\_\_\_

List ALL Medications you are currently taking

Women - How	many children?	Pregnant?	Date of last Menstrual Cycle	
Nursing?	Taking Birth Cont	rol Pills?		

\_\_\_\_\_

## **Accident Information-**

Date Accident Occurred\_\_\_\_\_

Describe how the Accident took place:

Were you the:  Driver  Front Passenger  Back Passenger  Pedestrian  Bike Automobile you were in: Year Make Model
Other Automobile: Year Make Model
Weather Condition: □ Sunny □ Dark □ Rainy □ Cloudy Street Surface: □ Dry □ wet □ slick □ Icy □ Under Construction
Where did the Accident happen? Street City/state
Where did the Accident happen? Street       City/state         Was it at?       A stop light       stop sign       while driving       controlled/uncontrolled intersection         other:
<b>Was the light:</b> □ Green □ Red □ Yellow □ Flashing □ Turn Arrow
How fast were you going?MPHThe other vehicle?MPHDid you see the impact coming?Did you brace for impact?
<b>Type of impact:</b> $\Box$ Rear end $\Box$ Front $\Box$ Side impact
Damage to your car:       Front       Rear       Driver Side       Passenger side       Bumper       Fender         Damage to other car:       Front       Rear       Driver Side       Passenger side       Bumper       Fender         Your Damage amount Estimate:       \$       Other Vehicle: \$       \$
Were you wearing a seatbelt?       Did air bags deploy?         On impact, your head was looking:       Forward       Behind       Up       Down       Left       Right         Did your body hit anything inside the car?       What body part?       What did it hit?       Did you loose consciousness?
Were you seen by the ambulance? Did they take you to the hospital?
Were you seen by the ambulance?Did they take you to the hospital?What hospital?Did they perform x-ray, MRI, CT?What was their diagnosis and treatment?
What was their diagnosis and treatment?
If no to the above, have you sought medical treatment? Explain?
How long after the accident did you seek care?
Since the accident have your pains gotten: □ Better □ Worse □ Remain unchanged Have you ever had these problems in the past?
Are you suffering from any of the following?       □ Headache       □ Nausea       □ Dizziness         □ Blurred vision       □ Ringing in ears       □ Radiating arm or leg pains       □ Loss of memory         □ Shortness of breath       □ Bladder/Bowel problems       □ Loss of memory

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care and/or legal providers. I authorize and request the insurance company or attorney to pay directly to this office any payable benefits.

Patient Signature\_\_\_\_\_ Date\_\_\_\_\_