Automobile/PI Accident or Work Comp Questionnaire

Abundant Life Chiropractic

Patient's Name _____ Date of Birth _____ Claim # _____

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 as neat and accurate as possible while completing this form. Thank you.

Please explain in detail how your accident happened:

_____

_____

_____

What was the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them?

_____

_____

_____

Did you require post-accident hospitalization? YES / NO

Check symptoms you have noticed since the accident:

_____Headache	_____Dizziness	_____Depression	_____Neck Pain
_____Lights Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Stiff
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Fainting
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Loss of Balance
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Nervousness
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Irritability
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Cold Sweats
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	
_____Shortness of Breath	_____Stomach Upset	_____Fatigue	

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? YES / NO If Yes, were you admitted? YES / NO How Long? _____

Name of Hospital: _____

Name of Doctor: _____

What treatment was given? _____

Was any other doctor consulted after your accident? YES / NO

If So, what was the doctor's name? _____

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had complaints in the involved area before? YES / NO

If so, what was the complaint? _____

Before the injury, were you capable of working on an equal basis with others your age? YES / NO

Are your work activities restricted as a result of this accident? YES / NO

Since this injury, are your symptoms: Improving? Getting Worse? Same?

Driver of other vehicle (if any):

Name: _____ Insurance Company: _____ Policy No. _____

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

Name: _____ Insurance Company: _____ Policy No. _____

Name of your Insurance Adjustor: _____

Have you retained an Attorney? YES / NO

Is so, his/her name and address: _____

You were heading: NORTH / EAST / SOUTH WEST on _____ (street or highway)

Other vehicle was heading: NORTH / EAST / SOUTH WEST on _____ (street or highway)

Were Police notified? YES / NO

Were you knocked unconscious? YES / NO

You were struck from: BEHIND / FRONT / LEFT SIDE / RIGHT SIDE

You were the: DRIVER / PASSENGER in the: FRONT SEAT / BACK SEAT

Using Seat Belt? YES / NO

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature Date