

# **CHIROPRACTIC HEALTH CENTER OF SOCASTEE**

## **Automobile/PI Accident or Work Comp Questionnaire**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#:

### **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 were 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:**

- |   |  |                                       |  |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Headache                 | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Depression   | <input type="checkbox"/> Fatigue         |
| <input type="checkbox"/> Light Bothers Eyes       | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Head Seems too Heavy     | <input type="checkbox"/> Memory Loss     | <input type="checkbox"/> Feet Cold    | <input type="checkbox"/> Neck Stiff      |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring       | <input type="checkbox"/> Hands Cold   | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Sleeping Problems        | <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Tension      | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Irritability    |
| <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Chest Pain   | <input type="checkbox"/> Cold Sweats     |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Stomach Upset   |                                       |  |

Symptoms other than above: \_\_\_\_\_  
\_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Hospitalized? Yes/ No If yes, admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Hospital \_\_\_\_\_

Name of Doctors \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted after your accident? Yes/ No

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**HR#:**

If 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? \_\_\_\_\_

How long did you see the doctor? \_\_\_\_\_

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? \_\_\_\_\_

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?

Drive 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

If 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 If so, for how long? \_\_\_\_\_

You were struck from Behind/ Front/ Left Side/ Right Side \_\_\_\_\_

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#:

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Doctor signature

\_\_\_\_\_  
DATE