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Automobile Accident Questionnaire

Print Form

Before beginning this document please be sure to have a printer attached to your computer. For security reasons, this file cannot be saved.

Patient Information

Todays Date

Last Name | First Name | Middle Initial | SSN

Address | City | State | Zip Code

☐ Male ☐ Female Date of Birth | Phone Number | Work Number

Your Employer | Occupation

Business Address | City | State | Zip Code

Are You: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's or Parent's Name | Employer | Work Number

Emergency Contact | Phone Number

Responsible Party

Name of the person responsible for this account | SSN

Relationship to the patient | Phone Number

Address | City | State | Zip Code

Name of Employer | Work Phone Number

Insurance Information

Name of the Insured | Relationship to the Patient

Date of Birth | SSN | Date Employed

Name of Employer | Work Phone Number

Address | City | State | Zip Code

Insurance Company | Phone Number

Group Number | Employer Number

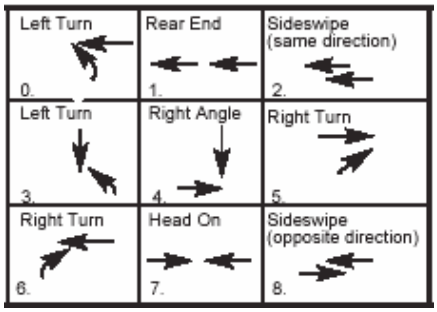
Insurance Address | City | State | Zip Code

How much is your deductible? | How much have you used? | Max annual benefit

Auto Accident

What was the date of the accident? and approximate time?

Please use the following space to explain in detail how your accident happened. In the box to the right, circle one of the diagrams as it best describes the accident or draw your own in the space provided. Number the vehicles involved with your vehicle as #1



You direction of travel was on (name of street or highway)

The other vehicles direction of travel was on (name of street or highway)

The vehicle struck you from If you were at fault, where did you strike the other vehicle?

Seatbelts used? Were police notified? Did you lose consciousness? If so, how long?

Injuries and Hospitalizations

Where did you feel the pain immediately after the accident?

List the extent of your injuries as you know them:

Where you taken to the hospital after the accident? If yes, were you admitted? How long?

Which hospital were you taken to? Doctor's name Specialty

Describe the treatment received including any tests performed.

Have you lost work days due to the accident? If so, how many days were missed?

Check any of the following symptoms that you have experienced since the accident:

- ☐ Headache
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Fainting
- ☐ Face Flushed
- ☐ Tension
- ☐ Buzzing in Ears
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Light Bothers Eyes
- ☐ Head Seems too Heavy
- ☐ Pins and Needles in Arms
- ☐ Pins and Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Sleeping Problems
- ☐ Shortness of Breath
- ☐ Depression
- ☐ Fatigue
- ☐ Irritability
- ☐ Nervousness
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Constipation
- ☐ Diarrhea
- ☐ Upset Stomach
- ☐ Cold Feet
- ☐ Cold Hands
- ☐ Fever
- ☐ Chest Pain
- ☐ Cold Sweats

Other

Were any other doctors consulted after the accident, other than those listed above?

Name of doctor | Specialty | What was the diagnosis?

What treatment was given? | How often did you see the doctor?

Have you ever had any complaints in the involved area before?

If so, what were your complaints?

Before the injury, were you capable of working on an equal basis with others your age?

Are your work activities restricted as a result of this accident?

Since this injury, are your symptoms

Is there anything else the doctor should know before the first visit?

Assignment and Release

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Perkins Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Perkins Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered unto me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Name | Patient's Signature _____ | Date

Parent or Guardian's Name | Signature _____

Once this document has been filled with your information it cannot be saved. This protects your health records from ever being viewed by a third party. To maintain this record it must be printed. Please bring this printed copy to your first appointment or fax the document to 417.885.1202. If you have any questions please call our office at 417.885.1200.