

# ACCIDENT HISTORY QUESTIONNAIRE

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_  
Sex  Male  Female How did you hear about the office? \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ AM/PM

Please Describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_  
City/State \_\_\_\_\_  
Driving Conditions:  Dry  Wet  Icy  Other \_\_\_\_\_  
Visibility:  Poor  Fair  Good  Other \_\_\_\_\_  
Was your vehicle moving?  Yes  No  
Speed of you vehicle: \_\_\_\_\_ mph

## YOUR VEHICLE

Make and model of your car: \_\_\_\_\_  
Were you wearing a seatbelt?  Yes  No  
Were shoulder harnesses worn?  Yes  No  
Did the airbag inflate?  Yes  No  
Did your seat have a headrest?  Yes  No  
If yes, what was the position of the headrest?  
 Top of headrest even with **bottom** of head  
 Top of headrest even with **top** of head  
 Top of headrest even with **middle** of neck  
Estimate the amount of damage done to your vehicle: \_\_\_\_\_

## OTHER VEHICLE

Make and model other vehicle \_\_\_\_\_  
Speed of other vehicle \_\_\_\_\_ mph

## IMPACT

Did your car impact another vehicle?  Yes  No  
Did your body strike anything inside the vehicle?  
 No  Yes, explain \_\_\_\_\_  
Type of Impact:  Front  Rear  Left  
 Right  Other \_\_\_\_\_  
Head/Body position at the time of impact:  
 Head straight forward  Body Straight  
 Head up/down  Body Rotated right/left  
 Head turned right/left  Other \_\_\_\_\_  
Did you see the accident coming?  Yes  No  
Did you brace for impact?  Yes  No  
Was your car braking?  Yes  No

## ILLUSTRATION OF THE ACCIDENT



**PATIENT CONDITON**

**Were you unconscious after the accident?**  Yes  No **If yes, for how long?** \_\_\_\_\_

**Could you move all parts of your body?**  Yes  No **If no, which parts couldn't you move and why?** \_\_\_\_\_

**Were you able to get out of the car and walk unaided?**  Yes  No, why not? \_\_\_\_\_

**Did you get any bleeding cuts?**  Yes  No **If yes, where?** \_\_\_\_\_

**Did you get any bruises?**  Yes  No **If yes, where?** \_\_\_\_\_

**Please describe how you felt, 1) immediately after the accident?** \_\_\_\_\_

**2) Later that day?** \_\_\_\_\_

**3) The next day?** \_\_\_\_\_

**TREATMENT**

**Did you go to the hospital immediately after the accident?**  Yes  No

**How did you get there?**  ambulance  police  someone else drove me  drove own car

**When did you go?**  Immediately after the accident  Next day  2 days or more after the accident

**Hospital Name:** \_\_\_\_\_ **Name of Doctor :** \_\_\_\_\_

**Treatment received:** \_\_\_\_\_

**Medications given:** \_\_\_\_\_

**X-rays taken:** \_\_\_\_\_

**Did you seek any additional treatment?**  Yes  No **If yes, who did you see?** \_\_\_\_\_

**Date of visit?** \_\_\_\_\_ **Treatment received:** \_\_\_\_\_

**SYMPTOMS**

**Have you missed any days at work since the accident?**  Yes  No **If yes, how many?** \_\_\_\_\_

**If you have had any of the following symptoms since the accident, please check off:**

- Arm/Shoulder pain
- Low back pain
- Neck pain
- Upper back pain
- Chest pain
- Leg pain
- Hand/finger numbness
- Foot/toe numbness
- Neck stiffness
- Headaches
- Irritability
- Nausea
- Stomach upset
- Chest pain
- Dizziness
- Ear ringing
- Memory Loss
- Jaw problems
- Sleep difficulty
- Blurred vision
- Shortness of breath

**Past health history: Place an x if it applies and describe:**

- None related to current complaints
- Other auto accident(s)
- Hospitalized
- Work Accident
- Surgery
- Illness

**Describe condition and treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"**

**Instructions: Please circle the correct response.**

**Historical Information**

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension)  Yes  No
  2. Hardening of the arteries (arteriosclerosis)  Yes  No
  3. Diabetes  Yes  No
  4. Heart or blood vessel diseases  Yes  No
  5. Bone spurs on the neck bones (cervical spondylosis)  Yes  No
  6. Whiplash injury (flexion-extension injury) (cervical spine)  Yes  No
  7. Have any of your relatives suffered a stroke?  Yes  No
  8. Were you ever a smoker? If yes, from \_\_\_\_\_ to \_\_\_\_\_  Yes  No
  9. Do you take any medications on a regular basis?  Yes  No
    - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)  
\_\_\_\_\_
  10. (Women Only) Have you ever taken oral Contraceptives?  Yes  No
    - If yes, from \_\_\_\_\_ to \_\_\_\_\_
  
- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision  Yes  No
  2. Double Vision  Yes  No
  3. Diminished or partial loss of vision in one or both eyes?  Yes  No
  4. Complete loss of vision in one or both eyes?  Yes  No
  5. Ringing, buzzing or any noise in the ear(s)?  Yes  No
  6. Hearing loss in one or both ears?  Yes  No
  7. Slurred speech or other speech problems?  Yes  No
  8. Difficulty swallowing?  Yes  No
  9. Dizziness?  Yes  No
  10. Temporary lack of understanding?  Yes  No
  11. Loss on consciousness, even momentary blackouts?  Yes  No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body?  Yes  No
  13. Any other abnormal sensations in any part of your body?  Yes  No
  14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs?  Yes  No
  15. Sudden collapse without loss of consciousness?  Yes  No

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

Dear Patient,

It is our desire that you have as pleasant an experience in our office as possible. Our most important concern is your health but we do need to do certain things to ensure that your personal injury bills will be taken care of. The following are a list of things all persons involved in an auto accident need to know about.

Please read the following and sign the bottom of this form.

1. YOUR insurance company is responsible for paying your bills, NOT the company of the person who hit you. If the accident was someone else's fault your insurance company will seek compensation from their insurance company. After the first \$2,000.00 of total Personal Injury Protection benefits are paid out, by law we must bill your health carrier. If your health carrier does not provide chiropractic benefit or if you do not have health insurance you PIP company will continue to pay your bills up to a total of \$8,000.00.
2. It is your responsibility to obtain the following information from your insurance company: Name, Address, Phone, and Fax number, as well as the claim number, name and extension of the Bodily Injury adjuster NOT the adjuster for your car.
3. Your insurance company will send you a form called a "PIP Application". This form must be filled out by you as soon as it is received. Your insurance company will not pay your bills until this form is on file with them. Failure to send in your PIP application will cause the bills to become your responsibility.
4. If you have decided to utilize the help of an attorney you and your attorney will need to sign a Lien form, which is held on file at this office. The Lien is used should you have any outstanding bills that are awaiting settlement to be paid.
5. At some point during your care your insurance company will send you to another doctor for an evaluation. This is called an IME or an Independent Medical Examination. Please inform this office immediately once you are notified of an IME.
6. Keeping your scheduled appointments are imperative, not only for your recovery but also to ensure your claims will be paid. If an insurance company sees you missing appointments or changing your treatment plan without the recommendation of our doctors, they will assume that you are recovered and no longer need care.

"I understand the above information and agree to comply fully with the office policies of

\_\_\_\_\_."

Signed \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Thank you for your time and cooperation.

**PERSONAL INJURY INSURANCE INFORMATION**

**PATIENT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_

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**YOUR AUTO INSURANCE INFORMATION (Or OWNER OF VEHICLE)**

**NAME OF INSURED** \_\_\_\_\_  
**(IF OTHER THAN YOURSELF)**

**NAME OF COMPANY** \_\_\_\_\_ **CLAIM #** \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ ADJUSTER \_\_\_\_\_ EXT # \_\_\_\_\_  
HAVE YOU HAD OR BEEN SCHEDULED FOR AN INDEPENDENT MEDICAL EXAM (IME)? \_\_\_\_\_

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**OTHER DRIVER'S INFORMATION**

NAME OF DRIVER \_\_\_\_\_

NAME OF COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

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NAME OF ATTORNEY \_\_\_\_\_ PHONE \_\_\_\_\_

By law in Massachusetts we must bill your personal health carrier after \$2,000.00 of personal injury benefits have been exhausted.

**PERSONAL HEALTH INSURANCE COMPANY** \_\_\_\_\_

Please provide our receptionist with a copy of your health insurance card.

I HEREBY AUTHORIZE \_\_\_\_\_ INSURANCE COMPANY TO PAY \_\_\_\_\_ DIRECTLY FOR MY HEALTH CARE COSTS. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO \_\_\_\_\_, AND I AGREE TO PAY ANY BALANCE OF PROFESSIONAL SERVICES OVER AND ABOVE THIS INSURANCE PAYMENT.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINANT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.

(Please read the above paragraph carefully before signing.)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

WITNESS \_\_\_\_\_