RIVER CITY CHIROPRACTIC
577 Braund Street, Onalaska WI 54650
(608) 406-2488

AUTO ACCIDENT QUESTIONNAIRE

PATIENT INFORMATION

Name_____ Today's Date _____/_____/_____

Address_____

Date of Birth _____/_____/_____ Primary Phone _____

INSURANCE

Auto Insurance Company _____ Claim # _____

Insurance Address _____

Name of Adjuster _____ Phone # _____

ATTORNEY

Name _____ Phone_____

Address _____

NATURE OF ACCIDENT

Date of Accident _____/_____/_____ Time of Accident _____ State Accident Occurred _____

Name of Responsible Party _____

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Front Seat ☐ Back Seat

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Approximate speed of your vehicle: _____mph Approximate speed of other vehicle: _____mph

Were you wearing a seat belt? ☐ Yes ☐ No Were police notified? ☐ Yes ☐ No

In your own words, please describe the accident: _____

_____

_____

Were you knocked unconscious? ☐ Yes ☐ No Did you require hospitalization? ☐ Yes ☐ No

What type of injuries did you receive? _____

_____

_____

Please describe how you felt:

- DURING the accident: _____
- IMMEDIATELY AFTER the accident: _____
- LATER THAT DAY: _____
- THE NEXT DAY: _____

Check the symptoms you have noticed since the accident:

☐ Headache	☐ Nervousness	☐ Cold Sweats	☐ Numbness in Toes	☐ Loss of Smell
☐ Neck Pain	☐ Irritability	☐ Dizziness	☐ Cold Feet	☐ Loss of Taste
☐ Neck Stiffness	☐ Depression	☐ Light Bothers Eyes	☐ Cold Hands	☐ Constipation
☐ Back Pain	☐ Fatigue	☐ Head Feels Heavy	☐ Shortness of Breath	☐ Diarrhea
☐ Chest Pain	☐ Sleeping Problems	☐ Tingling in Arms	☐ Memory Loss	☐ Other
☐ Fainting	☐ Tension	☐ Tingling in Legs	☐ Ringing in Ears	_____
☐ Flushed Face	☐ Fever	☐ Numbness in Fingers	☐ Loss of Balance	

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

Have you noticed any activity restrictions as a result of this injury? ☐ Yes ☐ No

If yes, please describe: _____

PREVIOUS CONDITION/EXPERIENCE

Did you have any physical complaints before the accident? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any congenital (from birth) factors which relate to this case? ☐ Yes ☐ No

Please describe: _____

Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

Please describe: _____

Have you ever been involved in an automobile accident before? ☐ Yes ☐ No

If yes, please describe, including date(s) and type(s) of accident(s), as well as injury(ies) received:

_____

_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office 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 this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 me will be immediately due and payable.

_____ _____

Patient Signature Date