Thiele Chiropractic & Wellness　　　　　　　　　　　　　File #: _______________
Patient Name: _________________________________　　　　Date: ____/____/_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

This information is considered confidential. We need this information because we care enough to want to know, and to help us determine if chiropractic care can benefit you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case and we will refer you to the most appropriate provider to help you. In order for us to understand your condition properly, please be as neat and thorough as possible while completing this form. Thank you.

Date of the injury? _____/_____/_____ Time of Day _______ AM/PM

You were: ☐Driver ☐Passenger ☐Front seat ☐Back seat Wearing a seat belt? ☐Yes ☐No

Was anyone else in the vehicle with you? ☐Yes ☐No **If Yes**, Number of People: ______

In which direction were you headed? ☐North ☐South ☐East ☐West

On which street? ____

Which direction was the other vehicle headed? ☐North ☐South ☐East ☐West

On which street? ____

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

What type of vehicle were you in? (Ex. Compact, SUV, Truck, etc.)_______________________________________

What type of vehicle was the other vehicle? ____

Were the police notified? ☐Yes ☐No Was an accident report filed? ☐Yes ☐No

Are you the owner of the vehicle? ☐Yes ☐No

If No, who is? ____

Please explain how the accident happened: ____

____

____

____

What symptoms did you have immediately after the accident? _______________________________________

____

____

List the extent of your injuries as you know them: ____

____

Check symptoms you have noticed since the accident:

☐ Headache	☐ Fainting	☐ Tension	☐ Bowel Changes
☐ Dizziness	☐ Light Sensitivity	☐ Irritability	☐ Sleep Problems
☐ Head Seems Heavy	☐ Buzzing/Ringing in Ears	☐ Nervousness/ Anxiety	☐ Difficulty Concentrating
☐ Neck Pain	☐ Pins and Needles in Arms	☐ Depression	☐ Shortness of Breath
☐ Neck Stiffness	☐ Pins and Needles in Legs	☐ Fatigue	☐ Stomach Pain
☐ Back Pain	☐ Numbness in Fingers	☐ Loss of Memory	☐ Cold Sweats
☐ Rib Pain	☐ Numbness in Toes	☐ Loss of Balance	☐ Face Flushed
☐ Chest Pain	☐ Cold Feet	☐ Loss of Smell	☐ Fever
☐ Arm/Leg Pains	☐ Cold Hands	☐ Loss of Taste	

Symptoms other than above: ____

Did you have any similar symptoms or complaints before the accident? ☐Yes ☐No

If Yes, describe: ____

____

Were you knocked unconscious? ☐Yes ☐No **If Yes**, for how long? ______________________________

Where were you taken after the accident? ____

Hospitalized? ☐Yes ☐No **If Yes**, admitted? ☐Yes ☐No How Long? ___________________________

Name of Hospital: ____

What was the diagnosis? ____

What treatment was given? ____

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

If Yes, Name of Doctor and Specialty: ____

What was the diagnosis? ____

What treatment was given? ____

How long ago did you see the doctor? ____

Since the injury, are your symptoms getting: ☐Worse ☐Improving ☐Staying the Same

Before your 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

Are your recreational activities restricted or limited as a result of this accident? ☐Yes ☐No

Approximately how much damage was done to your car? ____

Driver of other vehicle (if any): Name: ____

Insurance Company: ___________________________________ Policy #: _________________________

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

Insurance Company: _____________________________________ Policy #: _________________________

Name of your insurance adjustor: ____

Have you retained an attorney? ☐Yes ☐No

If Yes, Name and address: ____

____

______________________ _____/_____/_____ _________________________ _____/_____/_____

Patient Name (Printed) DOB Patient Signature Date

___________________________________ _____/_____/_____

Doctor Signature Date