MARTIN CHIROPRACTIC
Accident Questionnaire

Patient Name_____ Date_____

I. History of the Accident

A. Date of the Accident_____

B. Time of the Accident _____a.m._____p.m.

C. Specific Events of Accident:

1. Street(s) where the accident occurred

_____

2. Direction of Travel _____

5. Direction of Opposing traffic or other vehicle _____

6. Approximate Speed of your VEHICLE at time of the accident _____MPH

7. Approximate Speed of OPPOSING VEHICLE at the time of the accident _____MPH

   a. Road Conditions at the time of the accident __ Slippery ___Icy ___Dry ___Fog ___Other_____

   b. Where were you sitting in the vehicle at the time of the accident?_____

   _____

   c. A Brief Description of how the accident occurred_____

   _____

6. Was your vehicle towed away from the scene of the accident?___Yes___No

Was the Vehicle Totaled ? ___Yes___No

E. Did you go to the Hospital/Emergency Clinic following the accident?___Yes___No If Yes, Which Facility?_____

II. Medical Care

A. Have you had any X-Rays since the accident? ___Yes___No
Please list the facility where the films where taken_____

B. List the doctors names and phone numbers where you have been treated regarding this
accident_____

_____

C. List the medications that have been prescribed for you regarding this accident_____

D. List any other facilities where you are being treated regarding this accident_____

E. Is your pain worse in the ☐ Morning ☐ Afternoon ☐ Evening

F. Please list any activities /hobbies that have been interrupted due to your injuries sustained in this accident._____

_____

_____

III. LOCATION OF PAIN

Please indicate your pain level using the Visual Analog Pain Scale on the right

	Right Side	Left Side
Head		
Face		
Mouth		
Jaw		
Forehead		
Neck		
Right Shoulder		
Left Shoulder		
Right Arm		
Left Arm		
Right Elbow		
Left Elbow		
Right Forearm		
Left Forearm		
Right Wrist		
Left Wrist		
Right Hand		
Left Hand		
Mid-Back		
Low Back		
Chest		
Ribs		
Abdomen		
Hip		
Buttocks		
Thigh		
Knee		
Right Calf		
Left Calf		
Right Ankle		
Left Ankle		
Right Foot		
Left Foot		

Visual Analog Pain Scale

0	No Pain
1	Minimal Pain (Annoyance)
2	Constant Minimal to Intermittent Slight Pain
3	Constant Slight Pain (Some Handicap)
4	Constant Slight to Intermittent Moderate Pain
5	Constant Slight to Frequent Moderate Pain
6	Intermittent Moderate Pain (Markded Handicap)
7	Frequent Moderate Pain
8	Constant Moderate Pain
9	Constant Moderate to Intermittent Severe Pain
10	Constant Severe Pain (Incapacitated)

Additional Information _____

Frequency of Pain

Is Your Pain ☐ Constant ☐ Frequent ☐ Intermittent

IV. PAST MEDICAL HISTORY

A. List any current or previous Workers Compensation, Personal Injury Claims. Include dates or injuries and resulting disabilities if any. _____

_____

_____

B. List any major surgeries you have had _____

_____

C. List any current/previous health conditions that could complicate your condition as a result of this accident:

V. PERSONAL HISTORY

A. Your Date of Birth _____

B. Are You Married? ☐ Yes ☐ No

C. Do You Smoke? ☐ Yes ☐ No

D. Do You Drink Alcohol? ☐ Yes ☐ No

E. History of Drug Use? ☐ Yes ☐ No

F. Please list any changes in habit or lifestyle due to your injuries (e.g. work activities, domestic responsibilities, or recreational)

_____

_____

_____

_____

_____

_____

_____

_____

VI. INSURANCE

A.Are you covered by a group insurance plan? ☐ Yes ☐ No

Please list you ID #_____Phone #_____

_____

B.Are you covered by automobile insurance?

Name & Address of Insurance Company_____

Policy Number_____Claim Number_____

Adjuster Name and Phone Number_____

C. Please list any insurance information regarding the opposing vehicle's drivers _____

_____

_____

_____

D.Was a Police Report made at the time of the accident?

☐ Yes ☐ No If so, please attach a copy .

I certify that this information is complete and accurate.

_____ _____

Patient Signature **Date**

Please provide all **pictures** of your vehicle as well as any **additional information** regarding this accident with this questionnaire.