AUGER FAMILY CHIROPRACTIC
For a Better Life!

Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & model of your car: _____
   Year & model of other car: _____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other: _____
9. Road conditions at the time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark
   ☐ Other (describe) _____
10. Where was your car struck?

FRONT  BACK

In your own words, please describe accident: _____
_____
_____

11. Type of Accident: ☐ Head-on collision ☐ Broad-side collision
    ☐ Rear-collision ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:
    _____
13. Did you see the accident coming? ☐ Yes ☐ No
14. Did you brace for impact? ☐ Yes ☐ No
15. Were seat belts worn? ☐ Yes ☐ No
16. Where shoulder harnesses worn? ☐ Yes ☐ No
17. Does your car have headrests? ☐ Yes ☐ No
18. If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with bottom of head
    ☐ Top of headrest even with top of head
    ☐ Top of headrest even with middle of neck
19. Was your car braking? ☐ Yes ☐ No
20. Was your car moving at the time of the accident? ☐ Yes ☐ No
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____mph
23. Head/body position at the time of impact
    ☐ Head turned left/right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right/left
    ☐ Head straight forward ☐ Other: _____
24. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock
    ☐ Dazed, circumstances vague ☐ Other _____
25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or glasses? ☐ Yes ☐ No

27. Could you move all parts of your body? ☐ Yes ☐ No
28. If no, what parts couldn't you move and why?

_____

29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
32. Did you get any bruises? ☐ Yes ☐ No If yes, where?_____
33. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
34. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid back pain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other _____	

_____

35. Occupation: _____
36. Employer: _____
37. Have you missed time from work? ☐ Yes ☐ No
38. If yes, full time off work: _____to_____
39. If yes, part time off work: _____to_____
40. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
41. If yes, how did you get there? ☐ Ambulance ☐ Police
    ☐ Someone Else Drove Me ☐ Drove Own Car ☐ Other: _____
42. Doctor #1: Name: _____
43. First visit date: _____
44. Were you examined? ☐ Yes ☐ No
45. Were X-rays taken? ☐ Yes ☐ No
46. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
47. If yes, what kind of treatment did you receive? _____
48. What benefits did you receive from the treatment? _____
49. Date of last treatment? _____
50. Doctor #2: Name: _____
51. First visit date: _____
52. Were you examined? ☐ Yes ☐ No
53. Were X-rays taken? ☐Yes ☐ No
54. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
55. If yes, what kind of treatment did you receive? _____

_____ _____

Signature Date