Gilbert Chiropractic & Wellness

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MOTOR VEHICLE COLLISION QUESTIONNAIRE

Name____ Today's Date ____________
Last First Middle

ACCIDENT INFORMATION

Date of accident_______________ Time of accident________ a.m. p.m. Was the accident work related? Yes No

Were you the: Driver Front Passenger Rear Passenger Other ________ Number of people in the accident vehicle?______

Type of collision: head on rear end broad side front impact, rear ended car in front Other ______________

Did the impact to your vehicle come from the: Front Rear Right Side Left Side Other ______________

What did your vehicle impact? Another vehicle Nothing Other ______________________________

Did the police come to the accident site? Yes No Was a police report filed? Yes No

Was a citation/ticket issued? Yes No If yes, to whom and for what was it issued? ______________________

Were you wearing a shoulder harness? Yes No Were you wearing a lap belt? Yes No

Was the vehicle equipped with air bags? Yes No If yes, did they inflate? Yes No

Did any part of your body strike anything in the vehicle? Yes No If yes, please describe: ______________

____

In relation to your skull, where was the headrest? Above Below At base of skull Other ______________

During the impact, were you facing: Forward Right Left Other ______________________________

Were you aware of the upcoming impact? Yes No Were you braced for the upcoming impact? Yes No

Was your foot on the brake at impact? Yes No Was your foot on the clutch at impact? Yes No

Make, model and year of the vehicle you were occupying: ______________________________________

Make, model and year of the other vehicle(s) involved in the accident: ______________________________

What was the approximate speed of your vehicle? __________mph Approximate speed of the other vehicle? __________mph

In your own words, please describe the accident in detail: ______________________________________

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AFTER THE ACCIDENT

Did the accident render you unconscious? Yes No If yes, for how long? ______________ Describe how you felt immediately following the accident: ____

Have you gone to another Hospital/Doctor? Yes No Name of Hospital/Doctor: ______________________

When did you go? just after the accident the next day 2 days plus How did you get there? Ambulance Private Auto.

Were x-rays taken? Yes No If yes, please describe: ______________________________________

Was medication prescribed? Yes No If yes, what: ____________________

Describe any treatment you received: ____________________

Have you been able to work since the accident? Yes No Have you been working part time? Yes No

Please describe any work limitations/restrictions: ____________________

SYMPTOMS

Indicate symptoms that are a result of this accident: Dizziness Headaches Blurred vision Ears ringing Tension

Neck pain Neck stiff Jaw problems Arms/Shoulder pain Numb Hands/Fingers Chest pain Nausea Memory loss

Back pain Lower back pain Back stiffness Leg pain Numb Feet/Toes Stomach upset Buzzing in ear Fatigue

Irritability Other ____________ Is your condition getting worse? Yes No Constant Comes and goes

DRAW THE ACCIDENT

INSURANCE INFORMATION

Your Insurance Company____________________ Have you filed a claim? Yes NO

Insurance Co. Address (city state zip) ____________________

Insurance Telephone Number ____________________ Adjuster____________________

Do you have medical payments coverage Yes No Amount ____________________

Do you have under insured or uninsured coverage? Yes NO

Other Parties Insurance company ____________________Have you filed a claim? Yes NO

Insurance Co. Address (city state zip)____________________

Insurance Telephone number ____________________ Adjuster____________________

ATTORNEY INFORMATION

Do you have an attorney No Yes Name of Attorney ____________________

Attorney Address (city state zip) ____________________

Attorney Telephone number ____________________Paralegal____________________

Patient Signature____________________ Date____________________