Thompson Chiropractic Clinic

_____ _____

Patient's Name **DOB**

Automobile/PI Accident or Work Comp Questionnaire

Please answer all questions completely

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

Please explain in detail how your accident happened. _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

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

_____

_____

Did you require post accident hospitalization? ❑ No ❑ Yes

Check symptoms you have noticed since the accident:

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

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? ❑ No ❑ Yes If yes, admitted? _____How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

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

_____ _____

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If so, what was the doctor's name? _____ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

What was the diagnosis? _____

What treatment was given?_____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ❑ No ❑ Yes

If yes, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ❑ No ❑ Yes

Are your work activities restricted as a result of this accident? ❑ No ❑ Yes

Since this injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ Same?

Drive of other vehicle (if any)

Name_____ Insurance Company_____ Policy No. _____

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

Name_____ Insurance Company_____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ❑ No ❑ Yes

If yes, please provide their name and address _____

Your vehicle was heading ❑ North ❑ East ❑ South ❑ West on _____(street / highway)

Other vehicle was heading ❑ North ❑ East ❑South ❑ West on _____(street / highway)

Were police notified? ❑ No ❑ Yes

Were you knocked unconscious? ❑ No ❑ Yes If so, for how long? _____

You were struck from ❑ Behind ❑ Front ❑ Left Side ❑ Right Side_____

You were ❑ Driver ❑ Passenger ❑ Front seat ❑ Back Seat Using seat belts? ❑ No ❑ Yes

_____ _____

Patient's Name DOB

_____ _____

Patient signature DATE

_____ _____

Doctor signature DATE