# Crabtree Chiropractic Center, PA

**4517 Lead Mine Road, Raleigh NC, 27612**
**(919) 781-8830**

## Automobile Accident Questionnaire

**Patient Name_____ Today's Date_____**
(Please print)

Date of accident: _____
Were you the Driver _____Passenger (Front/Back Seat) _____ Pedestrian _____?
Who else was in the vehicle? _____
Were you on the job at the time of the accident? _____ Yes _____ No
If yes, were you driving your vehicle or a company vehicle? _____
Location of Accident: Street: _____ City: _____ State: _____
Were the police notified? _____ Yes _____ No was a ticket given? ____ Yes ___No
Who received the ticket? No one / other driver / don't know
Make of vehicle _____Model of vehicle _____Year of vehicle_____
Did the airbag(s) engage? _____ Yes _____ No
Amount of damage done to vehicle: No damage / Minimal, under $2,000 damage / Moderate, over $2,000 damage / Totaled, severe damage
If a total loss has occurred, what is the amount they determined the damage at? _____
What is the estimated value of your vehicle? _____
What is the make and model of the other vehicle involved? _____

**History of Accident**

_____ Stopped at red light or stop sign and rear ended.
_____ Head on collision - other vehicle traveling in opposite direction.
_____ Another vehicle ran a stop sign or red light.
_____ Did vehicle get hit into another vehicle or tree?
_____ Slowing down to make a stop or turn - rear ended.
_____ Lost control of vehicle____ Spun around _____ Rolled over.
_____ Side swiped.
_____ "T-Boned"?
_____ Other _____

Were you wearing seat belt / shoulder strap? _____ Yes _____ No
Did the seatbelt and shoulder strap engage? _____ Yes _____ No

Did you strike any objects inside the car? _____ Yes _____ No

_____ Steering column
_____ Dash Board
_____ Windshield
_____ Headrest
_____ Door Frame
_____ Jarred or thrown about
_____ Rear view mirror
_____ Seat Broke
_____ Cannot remember detail (dazed)
_____ Other_____
_____

Which way was your head turned at the time of impact? _____ right _____ left _____ straight
Were you leaning forward at the time of impact? _____ Yes _____ No
Was your body turned at the time of impact? _____ right _____ left _____ straight
Did you know you were going to be hit? ____ Yes ____ No If so, did you brace yourself? ____ Yes ___ No
What portion of your body did you strike? _____ Head, where in the vehicle? Steering column, side window, front window, rear window (truck) or headrest _____ Chest _____ Face _____ Knees _____ Arms _____Other_____

**Patient Name**_____ **Today's Date**_____
(Please print)

Were you rendered unconscious, cut, or bleeding? _____ Yes _____ No
If cut, please explain where: _____

Did you experience immediate pain, please indicate:
_____ Headache ____ right ____ left
_____ Neck pain ____ right ____ left
_____ Mid back pain ____ right ____ left
_____ Low back pain ____ right ____ left
_____ Leg pain ____ right ____ left
_____ Arm pain ____ right ____ left
_____ Other _____

After the accident, did you:
_____ Go Home _____ Go about your business _____ Go to the hospital

## HOSPITALIZATION

If taken to the hospital, how? ____ Ambulance _____ Drove myself
____ Driven by a friend/relative ____Went home and later taken or drove to the hospital.

Name of Hospital: _____
___ Western Wake ___ Raleigh Community ____Wake Medical ___ Rex ____Other

Were you seen in the emergency room? _____ Yes _____ No
Were you admitted to the hospital? _____ Yes _____ No
If admitted, how long did you stay? _____
Name of admitting or hospital physician: _____

In the emergency room or hospital, what was done?
_____ Examination _____ Stitches
_____ X-rays _____ Physical Therapy
_____ Cervical Collar _____ Complete Bed rest
_____ Prescription given _____ Hot or cold therapy
_____ Referral to another doctor _____ Other: _____

After your release what did you do?
_____ Return home to bed _____ Return to work _____
_____ Other _____

When did you first consult a physician?
____ Same day ____ Following day ____ Within a few days ____ Other: _____

If you consulted this office first, skip to PAST HISTORY.

Who did you consult? Dr. _____
_____ Family physician _____ Chiropractor
_____ Orthopedist _____ Osteopath
_____ Neurologist _____ Other: _____

**Patient Name**_____ **Today's Date**_____
(Please print)

What did the doctor do?

_____ Chiropractic manipulation _____ Examination
_____ Injections _____ X-rays
_____ Traction _____ Prescriptions
_____ Physical Therapy _____ Other: _____

If physical therapy was rendered, how long: _____
Where did you receive these treatments?
_____ Hospital _____ At Primary Care Physician office

How long were you under the care of this physician? _____
Are you still under his/her care? _____ Yes _____ No
Frequency or number of visits now: _____

Did the doctor refer you to or have you been to any other physicians? ____ Yes ____ No
Explain: _____

Other pertinent information: _____
_____

**PAST HISTORY**

Have you ever been in a previous auto accident? _____ Yes _____ No
If yes, please give dates and details: _____
_____
_____

Do you have lasting symptoms or are you still being treated for that accident? If yes, please explain:
_____
_____

Have you ever been treated for neck or back problems by any other physicians prior to this current accident?
_____ Yes _____ No If yes, please explain: _____
_____

Have you enjoyed good health prior to this accident? _____ Yes _____ No
If no, explain: _____

**DISABILITY**

Have you lost any time from work since the accident? _____ Yes _____ No
How many days? _____
Still off work? _____ Yes _____ No
Job Description: _____

Any additional comments or details you feel would be helpful regarding this accident?
_____