Crabtree Chiropractic Center, PA 4517 Lead Mine Road, Raleigh NC, 27612 (919) 781-8830

Automobile Accident Questionnaire

Patient Name	Patient Name	Today's I	Oate	
Were you the Driver	(Please print)	·		
Were you the Driver	Date of accident:			
Were you on the job at the time of the accident?Yes	Were you the DriverPassenger (Pedestrian?	
f yes, were you driving your vehicle or a company vehicle?	Who else was in the vehicle?			
State: 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 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 Totaled, with totale Totaled, with totale Totaled, with totaled, with totaled, with totaled, with totaled, severe damage Totaled, with totaled, severe damage Totaled, with totaled, severe damage Totaled, severe damage Totaled, severe damage Totaled, severe				
Who received the ticket? No one / other driver / don't know Make of vehicle	If yes, were you driving your vehicle or a	company vehicle?		
Who received the ticket? No one / other driver / don't know Make of vehicle	Location of Accident: Street:	City:	State:	
Who received the ticket? No one / other driver / don't know Make of vehicle	Were the police notified? Yes	No was a ticket gi	ven? YesNo	
Amount of damage done to vehicle: No damage / Minimal, under \$2,000 damage / Moderate, over \$2,000 damage / Cortaled, severe damage f a total loss has occurred, what is the amount they determined the damage at?	Who received the ticket? No one / other	driver / don't know		
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Door Frame Jarred or thrown about 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 What portion of your body did you strike? Head, where in the vehicle? Steering column, side window				
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	What portion of your body did you strike	? Head, where in	the vehicle? Steering colum	n, side windo
Tillib				

Patient Name	Today's Date
(Please print)	
Wara you randarad unaansajous	e out or blooding? Vos No
	s, cut, or bleeding? Yes No
ii cut, piease expiani where.	
Did you experience immediate	nain nlease indicate:
-	right left
	right left
<u> </u>	rightleft
Low back pain	
	rightleft
	rightleft
Other	
After the accident, did you:	
-	oout your business Go to the hospital
	•
HOSPITALIZATION	
-	Ambulance Drove myself
Driven by a friend/relative	eWent home and later taken or drove to the hospital.
Name of Hospital:	
Western Wake Raleig	th CommunityWake Medical RexOther
•	y room? Yes No
•	tal? Yes No
If admitted, how long did you s	
Name of admitting or hospital p	ohysician:
T .1	
In the emergency room or hospi	
	Stitches
X-rays	Physical Therapy
Cervical Collar	Complete Bed rest
Prescription given	Hot or cold therapy
Referral to another doct	torOther:
A from vious malogogo vishot did viou	4.9
After your release what did you	
Return home to bed	
Other	
When did you first consult a mb	veician?
When did you first consult a ph	
Same day Followin	ng day Within a few days Other:
If you conculted this office first	alde to DACT HICTODY
If you consulted this office first	, SKIP 10 PAST HISTORY.
Who did you consult? Dr	
	Chiropractor
Family physician	
Orthopedist	Osteopath
Neurologist	Other:

Patient Name	Today's Date
(Please print) What did the doctor do?	
	Examination
Injections	X-rays
Traction	A-lays Prescriptions
Physical Therapy	Other:
I nysicai Therapy	Other.
If physical therapy was rendered how long:	
Where did you receive these treatments?	
Hospital At Primary Care I	Physician office
How long were you under the care of this phy	ysician?
Are you still under his/her care? Ye	₹
Did the doctor refer you to or have you been Explain:	· · · · · · · · · · · · · · · · · · ·
Other pertinent information:	
PAST HISTORY Have you ever been in a previous auto accide If yes, please give dates and details:	ent? Yes No
Do you have lasting symptoms or are you still	ll being treated for that accident? If yes, please explain:
•	problems by any other physicians prior to this current accident? xplain:
Have you enjoyed good health prior to this ac If no, explain:	ccident? Yes No
DISABILITY Have you lost any time from work since the a How many days? Still off work? Yes Lob Description:	No
Job Description: Any additional comments or details you feel	
Any additional comments of details you feel	would be helpful regarding this accident?