File No. _____

FAMILY CHIROPRACTIC & NATURAL HEALING CENTER

Vehicle Injury Questionnaire

PLEASE PRINT

LEGAL FIRST NAME: _____ **M.I**._____ **LAST NAME**: _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day: _____ (AM / PM)
2. Were you: □Driver □Passenger □Front Seat □Back Seat
3. Number of People in your vehicle: _____ Other vehicle: _____
4. Were you struck from: □Behind □Front □Left Side □Right Side □Auto was parked
5. Did your car strike the other(s) involved? □Yes □No or; Did the other car strike yours? □Yes □No
6. Were you knocked unconscious? □Yes □No If Yes, for how long? _____
7. Was a Police report made? □Yes □No
8. Were traffic citations issued to you? □Yes □No; To the other Driver? □Yes □No
9. Were you taken to the emergency room? □Yes □No; What Hospital? _____
10 Have you been treated by another doctor since the accident? □Yes □No; If yes, what type of treatment did you receive? _____
11. Were X-Rays taken? □Yes □No If yes, where and when? _____
12. In your own words, please describe the accident: _____
13. Did you have any physical complaints BEFORE THE ACCIDENT? □Yes □No If Yes, please describe in detail:_____
14. Please describe how you felt:
    a. IMMEDIATELY AFTER the accident: _____
    b. LATER THAT DAY: _____
    c. THE NEXT DAY: _____
15. What are your PRESENT complaints and symptoms? _____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Unbearable Pain)

16. Since this injury occurred, are your symptoms: □Improving □Getting Worse □Same
17. Have you ever received chiropractic treatment? □Yes □No. If Yes, by whom? _____
18. Have you lost time from work as a result of this accident? □Yes □No. Last Date worked _____
19. Do you notice any activity restrictions as a result of this injury? □Yes □No. (I.e. At home, work, resting, recreational, or sleep.) Describe in detail: _____
20. Have you ever been involved in an accident before? □Yes □No. If Yes, please describe, including date(s) and type(s) of accidents, as well as injury (ies) received: _____

21. Other pertinent information:

_____

_____

_____

22. Have you retained an attorney? □Yes □No. If Yes, provide name_____

Ph#_____ Address_____

City_____ State_____ Zip_____

Health and accident insurance policies are an arrangement between the insurance company and you. This office will prepare any necessary reports and forms to process your claim. Any charges not paid by insurance will be the patient's responsibility and payable at the time service is rendered.
I authorize Dr. Lind to examine and treat my condition as deemed appropriate through the use of Chiropractic Care, Homeopathic remedies, Traditional Chinese Medicine, and other natural healing methods. □Yes □No

_____

Patient Signature

_____ _____

Legal Guardian **Date**

Revised Dtd: