FINN CHIROPRACTIC

Welcome to our office!

AUTOMOBILE ACCIDENT QUESTIONNAIRE

NAME (first, middle, last):_____

MAILING ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____ SS#_____-_____-_____ DOB:_____

HOME PHONE:_____ CELL PHONE:_____ SEX: M_____ F_____

EMPLOYER: _____ WORK PHONE:_____

RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS:_____ _____ SS#: _____-_____-_____ DOB:_____

EMERGENCY CONTACT (who does not live with you): _____

ADDRESS:_____ PHONE: _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

DATE OF ACCIDENT; _____ TIME OF ACCIDENT: _____

LIABILITY CARRIER (other party ins. company): _____

DRIVER: _____ NAME OF INSURED: _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

DRIVER OF VEHICLE IN WHICH YOU WERE INJURED: _____

AUTO/MED CARRIER (driver's ins. company): _____

DRIVER: _____ NAME OF INSURED: _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

NAME OF YOUR INSURANCE ADJUSTER: _____

HAVE YOU RETAINED AN ATTORNEY? ❑ YES ❑ NO

IF SO, ATTORNEY'S NAME AND ADDRESS: _____

DO YOU WANT TO FILE THIS WITH YOUR GROUP HEALTH INSURANCE? ❑ YES ❑ NO

IF SO, INSURANCE CARRIER NAME: _____

SUBSCRIBER NAME:_____RELATIONSHIP TO PATIENT:_____

SUBSCRIBER ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

DOB:_____/_____/_____ SS#:_____-___-_____ EMPLOYER:_____

INSURANCE CO:_____

INSURANCE ADDRESS:_____

ID#: _____ GROUP #:_____

We invite you to discuss with us any question regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. I understand the above information and guarantee the Auto Accident Questionnaire was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. With my signature below, I hereby understand and authorize the statements above.

Signature: _____ Date: _____

PLEASE DESCRIBE HOW THE ACCIDENT HAPPENED: _____

_____

_____

_____

_____

_____

_____

_____

_____

WAS ANYONE ELSE IN THE VEHICLE WITH YOU? ❑ YES ❑ NO

NAME	RELATIONSHIP	AGE	INJURED?

TOTAL NUMBER OF VEHICLES INVOLVED IN THE ACCIDENT: ❑ 1 ❑ 2 ❑ 3 ❑ 4

THE IMPACT TO YOUR VEHICLE OCCURRED FROM THE: ❑ FRONT ❑ REAR
❑ LEFT SIDE ❑ RIGHT SIDE
❑ OTHER

TOTAL NUMBER OF IMPACTS TO YOUR VEHICLE: ❑ 1 ❑ 2 ❑ 3 ❑ 4

WERE YOU ON COMPANY BUSINESS AT THE TIME OF THE ACCIDENT? ❑ YES ❑ NO
IF YES, WAS THE ACCIDENT REPORTED TO THE EMPLOYER? ❑ YES ❑ NO

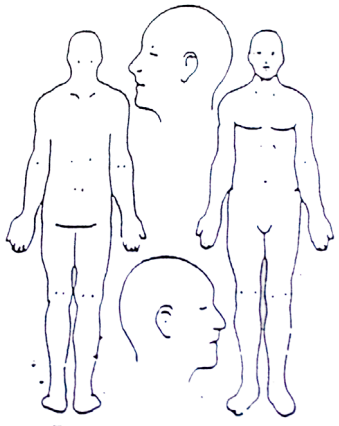
WERE YOU WEARING ❑ A LAP BELT
❑ LAP AND SHOULDER BELT
❑ NEITHER

WAS A HEADREST PRESENT? ❑ YES ❑ NO

DID ANY WINDOWS BREAK IN YOUR VEHICLE? ❑ YES ❑ NO
IF YES, LIST WHICH WINDOWS BROKE: _____
WAS THERE ANY FLYING GLASS FROM THE IMPACT? ❑ YES ❑ NO
IF YES, DESCRIBE: _____

DID YOU RECEIVE ANY
- ❑ CUTS
- ❑ BRUISES
- ❑ ABRASIONS

MARK ON THE DIAGRAM
WHERE THE INJURIES OCCURRED
USE "C" FOR CUTS
USE "B" FOR BRUISES
USE "A" FOR ABRASIONS



AT THE TIME OF THE ACCIDENT DID YOU LOSE:

CONSCIOUSNESS ❑ YES ❑ NO
BOWEL OR BLADDER CONTROL ❑ YES ❑ NO
FLUID FROM THE EARS ❑ YES ❑ NO

DID YOU HAVE ANY OTHER UNUSUAL EXPERIENCE? ❑ YES ❑ NO
IF YES, DESCRIBE: _____

_____

MAKE AND MODEL OF YOUR VEHICLE: _____ YEAR: _____

PLEASE DESCRIBE ANY DAMAGE DONE TO YOUR VEHICLE: _____

_____

_____

MAKE AND MODEL OF OTHER VEHICLE: _____ YEAR: _____

PLEASE DESCRIBE ANY DAMAGE DONE TO OTHER VEHICLE: _____

_____

_____

WERE YOU ABLE TO GET YOURSELF OUT OF THE VEHICLE? ❑ YES ❑ NO
IF NO, WHO HELPED YOU? _____

PLEASE DESCRIBE HOW YOU WERE REMOVED FROM YOUR VEHICLE: _____

_____

WHO WAS CALLED OR CAME TO THE SCENE?

HIGHWAY PATROL	❑ YES	❑ NO
LOCAL POLICE	❑ YES	❑ NO
SHERIFF	❑ YES	❑ NO
PARAMEDICS	❑ YES	❑ NO
AMBULANCE	❑ YES	❑ NO
OTHER _____		

WAS A REPORT MADE? ❑ YES ❑ NO

DO YOU HAVE A COPY OF THE REPORT? ❑ YES ❑ NO

DID YOU RECEIVE FIRST AID AT THE SCENE? ❑ YES ❑ NO
IF YES, BY WHOM? _____
WHAT, SPECIFICALLY, WAS DONE TO YOU? _____

_____

DID YOU GO TO THE EMERGENCY ROOM? ❑ YES ❑ NO

DID YOU GO TO THE DOCTOR'S OFFICE? ❑ YES ❑ NO

IF YOU ANSWERED "YES" TO EITHER OF THE ABOVE TWO QUESTIONS, COMPLETE THE FOLLOWING:

A. WHO ATTENDED TO YOU THERE? _____

B. WHAT WAS DONE FOR YOU THERE?

EXAMINATION	❑ YES	❑ NO
MEDICATION	❑ YES	❑ NO
PAIN MEDICINE	❑ YES	❑ NO
MUSCLE RELAXANTS	❑ YES	❑ NO
ANTI-INFLAMMATORIES	❑ YES	❑ NO
SUPPORTS/BRACES	❑ YES	❑ NO
X-RAYS	❑ YES	❑ NO
OTHER _____		

C. WHAT DIAGNOSIS WERE YOU GIVEN? _____
D. WERE YOU TOLD TO DO ANYTHING BY THE DOCTOR IN ATTENDANCE? ❑ YES ❑ NO
IF YES, PLEASE DETAIL: _____

_____

WERE YOU HOSPITALIZED AT ANY TIME AS A RESULT OF THE INJURIES YOU SUSTAINED FROM THE ACCIDENT:
❑ YES ❑ NO

IF YES, PLEASE COMPLETE:

NAME OF HOSPITAL/LOCATION	ENTERED/DISCHARGED	TREATING DOCTOR
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT WAS DONE FOR YOU AT THE HOSPITAL?_____

_____

_____

PLEASE DESCRIBE HOW YOU FELT?

A. IMMEDIATELY AFTER THE ACCIDENT? _____

_____

_____

B. LATER THAT DAY? _____

_____

_____

C. THE NEXT DAY? _____

_____

_____

DID YOU SEE ANY OTHER HEALTH CARE PROFESSIONAL SINCE THE FIRST DAY OF THE AUTO ACCIDENT? ❑ YES ❑ NO

IF YES, COMPLETE THE FORM BELOW. BEGIN WITH THE PERSON YOU SAW FIRST AND PROCEED TO THE MOST RECENT.

NAME	TITLE	DATE(S) SEEN	WHAT WAS DONE FOR YOU?

HAVE YOU HAD ANY INJURY OR ILLNESS OF ANY TYPE SINCE THE AUTO INJURY? ❑ YES ❑ NO

IF YES, PLEASE DESCRIBE:_____

_____

_____

HAVE YOU EVER HAD ANY SIGNIFICANT INJURY OR ILLNESS OF ANY TYPE **PRIOR** TO THE AUTO INJURY? ❑ YES ❑ NO
IF YES,

- WHAT WAS THE NATURE OF THE PROBLEM AND WHEN DID IT OCCUR?
- IF PROFESSIONAL CARE WAS RENDERED, HOW LONG WERE YOU TREATED, BY WHOM, AND WHAT WAS DONE?

HAVE YOU EVER HAD ANY PHYSICAL COMPLAINTS SIMILAR TO THOSE YOU ARE NOW EXPERIENCEING, PRIOR TO THIS AUTO INJURY? ❑ YES ❑ NO
IF YES, WHAT WAS THE NATURE OF THE COMPLAINTS, WHAT WAS DONE FOR THEM, WHEN, AND BY WHOM?

PRIOR TO THIS AUTO INJURY, HAVE YOU EVER BEEN HOSPITALIZED FOR ANY REASON? ❑ YES ❑ NO
IF YES, WHAT WAS THE NATURE OF THE COMPLAINT OR ILLNESS, WHEN WERE YOU HOSPITALIZED, FOR HOW LONG, AND WHAT TREATMENT WAS RENDERED?

HAVE YOU EVER HAD ANY SURGERIES? ❑ YES ❑ NO

IF YES, WHEN, WHAT FOR, AND BY WHOM?

ARE YOU AWARE OF ANY CONGENITAL (FROM BIRTH) ABNORMALITIES YOU MAY HAVE? ❑ YES ❑ NO

IF YES, PLEASE DESCRIBE:

HAVE YOU EVER HAD A NERVOUS OR MENTAL CONDITION? ❑ YES ❑ NO
ANY PSYCHOLOGIAL OR PSYCHIATRIC CARE? ❑ YES ❑ NO
IF SO, WHAT WAS THE NATURE OF THE PROBLEM, WHAT TYPE OF TREATMENT WAS RENDERED, WHEN, AND BY WHOM?

HAVE YOU EVER SERVED IN THE ARMED FORCES? ❑ YES ❑ NO
IF YES, WHAT WERE THE DATES OF SERVICE AND WHAT TYPE OF DISCHARGE DID YOU RECEIVE?

_____

_____

_____

HAVE YOU EVER BEEN PLACED DISABILITY, EVEN FOR A BRIEF PERIOD OF TIME? ❑ YES ❑ NO

IF YES, WHEN AND FOR WHAT REASON?_____

_____

HAVE YOU EVER RECEIVED AN AWARD OF PERMANENT DISABILITY? ❑ YES ❑ NO

IF YES, WHEN, FOR WHAT REASON, AND BY WHOM? _____

_____

_____

HAVE YOU EVER BEEN TOLD BY A MEDICAL DOCTOR, CHIROPRACTOR, OSTEOPATH, OR OTHER HEALTHCARE PROFESSIONAL TO NOT DO A CERTAIN TYPE OF PHYSICAL ACTIVITY ON A PERMANENT BASIS? ❑ YES ❑ NO
IF YES, WHAT WAS THE RESTRICTION, WHEN WAS IT GIEN, BY WHOM, AND FOR WHAT REASON?

_____

_____

_____

ARE YOU CURRENTLY UNDER ANY OTHER DOCTOR'S CARE? ❑ YES ❑ NO
IF YES, WHO IS THE DOCTOR, HOW LONG HAVE YOU BEEN SEEN BY THIS PHYSICIAN, AND WHAT IS THE DOCTOR

TREATING YOU FOR? _____

_____

_____

HAVE YOU EVER BEEN SEEN BY THIS OFFICE PRIOR TO TODAY? ❑ YES ❑ NO

IF YES, WHEN, BY WHOM, AND FOR WHAT REASON? _____

_____

_____

HOW DID YOU HAPPEN TO CHOOSE THIS OFFICE?_____

WHICH SYMPTOMS HAVE IMPROVED? _____

_____

WHICH SYMPTOMS HAVE GOTTEN WORSE? _____

_____

WHICH SYMPTOMS HAVE REMAINED BASICALLY UNCHANGED? _____

_____

WHAT MEDICATIONS - PRESCRIBED OR NOT - ARE YOU CURRENTLY TAKING TO TREAT SYMPTOMS OF YOUR INJURY?

_____

_____

_____

WHAT OTHER MEDICATIONS - PRESCRIBED OR NOT - ARE YOU CURRENTLY TAKING FOR PROBLEMS UNRELATED TO YOUR INJURY? _____

_____

_____

DO YOU CURRENTLY SMOKE? ❑ YES ❑ NO

IF YES, ON AVERAGE, HOW MUCH DO YOU SMOKE PER DAY? _____

DO YOU CURRENTLY DRINK ALCOHOL ❑ YES ❑ NO

IF YES, HOW MUCH AND HOW OFTEN? _____

DO YOU HAVE ANY RECREATIONAL OR HOBBY ACTIVITIES? ❑ YES ❑ NO

IF YES, WHAT ARE THEY? _____

_____

_____

OTHER THAN YOUR PRESENT COMPLAINTS THAT STEM FROM THE AUTO INJURY BEING CONSIDERED, HOW DO YOU RATE YOUR OVERALL HEALTH?_____

ARE YOU CURRENTLY EMPLOYED?❑ YES ❑ NO

IF YES, WHAT IS YOUR JOB TITLE? _____

WHAT ARE YOUR JOB DUTIES? _____

HAVE YOU MISSED ANY WORK AS A RESULT OF THE AUTO ACCIDENT? ❑ YES ❑ NO

IF YES, PLEASE DETAIL: _____

DO YOU HAVE AN ATTORNEY FOR THIS CASE: ❑ YES ❑ NO

IF YES, WHO IS IT AND WHAT IS THE LOCATION OF HIS/HER OFFICE?_____

_____

IN THE SPACE BELOW, PLEASE INDICATE ANY ADDITIONAL INFORMATION THAT YOU BELIEVE I SHOULD KNOW ABOUT YOUR CASE:_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICAL COMPLAINTS

Please use the space provided below to describe any medical complaints you are currently experiencing, or for any additional comments you may wish to make regarding your condition.

_____

_____

_____

_____

_____

_____

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.

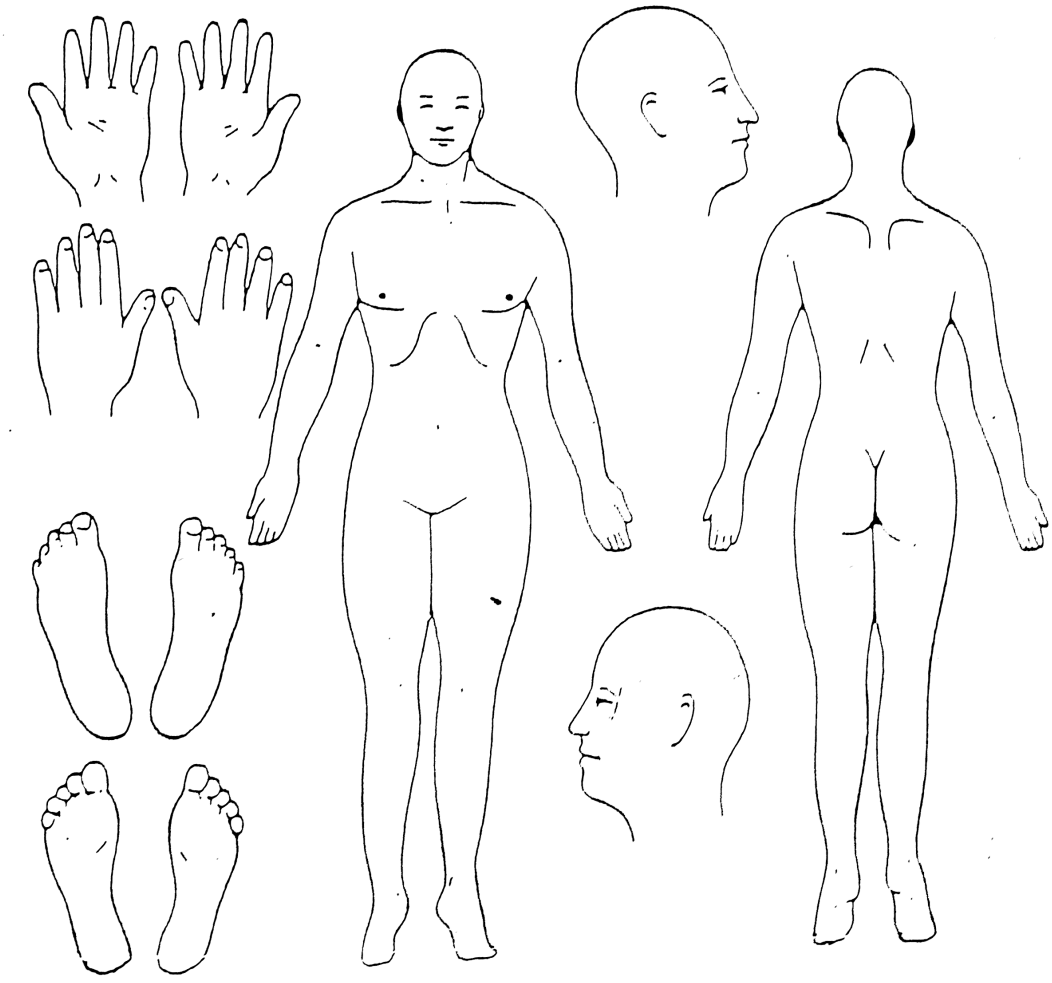
Numbness = =
= =

Pins and Needles > > >
> > >

Burning x x
x x

Stabbing Pain / /
(sharp) / /

Aching pain (((
(dull)



INSTRUCTIONS: PLEASE PRINT YOUR RESPONSE OR CIRCLE THE MOST APPROPRIATE CHOICE(S)

Patient Name: _____

	WHAT BOTHERS YOU MOST?	NEXT MOST?	NEXT?
WHEN DID THIS PROBLEM BEGIN?			
THIS PROBLEM BEGAN:	gradually suddenly	gradually suddenly	gradually suddenly
THIS PROBLEM CAN BEST BE DESCRIBED AS:	sharp dull burning throbbing stabbing tingling other _____	sharp dull burning throbbing stabbing tingling other _____	sharp dull burning throbbing stabbing tingling other _____
THIS PROBLEM IS:	constant near constant frequent rarely present other _____	constant near constant frequent rarely present other _____	constant near constant frequent rarely present other _____
THIS PROBLEM IS WORSE WITH:	coughing sneezing straining sleeping lifting rest activity weather changes other _____	coughing sneezing straining sleeping lifting rest activity weather changes other _____	coughing sneezing straining sleeping lifting rest activity weather changes other _____
THIS PROBLEM IS BETTER WITH:	medication rest activity stretching treatment other _____	medication rest activity stretching treatment other _____	medication rest activity stretching treatment other _____

WHICH HOUSEHOLD, SOCIAL, RECREATIONAL, OR WORK ACTIVITIES ARE NOW DIFFICULT OR IMPOSSIBLE TO DO BECAUSE OF YOUR PROBLEM(S)? _____

_____

_____

_____

Patient Signature: _____