



Natural Inner Health®

200 D Main Street
Stoneham, MA 02180
781-438-9355

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Today's Date: _____

Patient's Name: _____

Date of your accident: _____

When did symptoms first appear: _____

Please describe how the accident occurred: _____

Where you the: Operator: Passenger Pedestrian

Name of person driving at time of accident (if not yourself): _____

Name of the auto Insurance Carrier for the vehicle you were in: _____

Has the accident been reported to the insurance company? Yes No

Name of the claims adjuster assigned to your claim: _____

Claim number assigned to your claim: _____

Has your personal injury protection form been completed and sent to the insurance carrier?: Yes No

When was it sent? _____

Was this accident reported to the police? Yes No When _____

Did you receive a copy of the police report? Yes No

Have you contacted an attorney to handle your claim? Yes No

Attorney's Name: _____

Attorney's Phone Number: _____

If another vehicle was involved in your accident, the following information is required:

Name of automobile owner: _____

Automobile insurance carrier: _____

Where you taken to the hospital or treated at the emergency room? Yes No

When: _____ Where: _____

I understand that if my bill for service rendered, by Atlantic Chiropractic, is not paid by the responsible automobile insurance carrier or carriers involved in this accident or through my own health insurance company, that I will remain personally responsible for payment of my medical treatment in full. I also understand that in the event that insurance checks are made payable to and cashed by me that I will be responsible for reimbursement to Atlantic Chiropractic for all services rendered. I further understand that if my claim is denied by the automobile insurance carrier due to my lack of co-operation I will remain personally responsible for payment of my medical bills to Atlantic Chiropractic in full for all services rendered.

Patient Signature: _____ Date _____ :



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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Chief Complaint: Headaches Neck Pain Mid Back Pain
 Low Back Pain Shoulder Pain Leg Pain

Other-pain radiates from: _____ To: _____

Rate Severity of Problem from 1 (best) to 5 (worst) _____

Duration of Symptoms: Intermittent (25% of the time); Occasional (25% to 50%); Frequent (50% to 75%);
Constant (75% to 100%); Other (i.e. with movement or position)

Character: Dull Pain/Ache; Sharp/Stabbing; Burning; Numbness/Tingling; Throbbing; Other (Explain):

Relieving Factors: Rest, Exercise, Bracing/Taping; Sitting; Standing; Lying Down; Hot Rocks; Cold Packs; Other:

Aggravating Factors: Coughing; Sneezing; Lifting; Bending; Pushing; Pulling; Driving; Riding; Sitting; Standing;

Walking; Running; Other: _____

Are you presently taking any medications? Yes No

If yes, please supply name of the medication and why it was prescribed: _____

Have you had surgery in the last two years Yes No

If yes, please explain: _____

Do you have any of the following symptoms?:

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Shortness of Breadth | <input type="checkbox"/> Numbness in Toes/Fingers | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Buzz/Ring in Ears | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Heavy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fever | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Loss of Smell | | <input type="checkbox"/> Cold Feet |

Other (Explain) _____

PAIN DIAGRAM

BACK

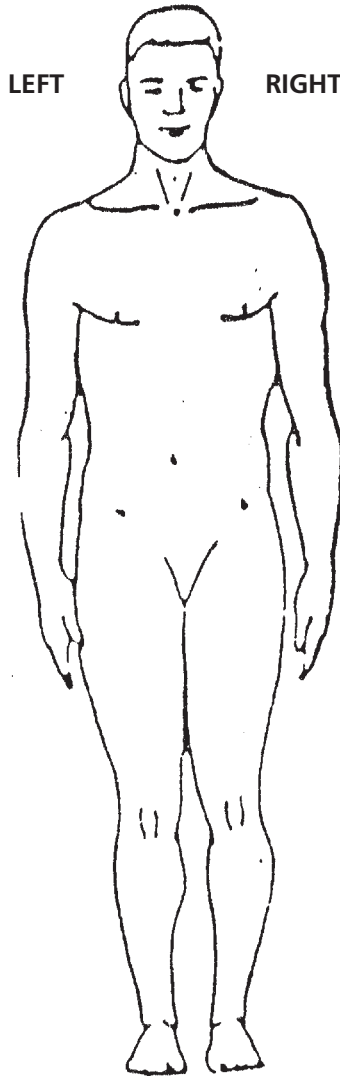
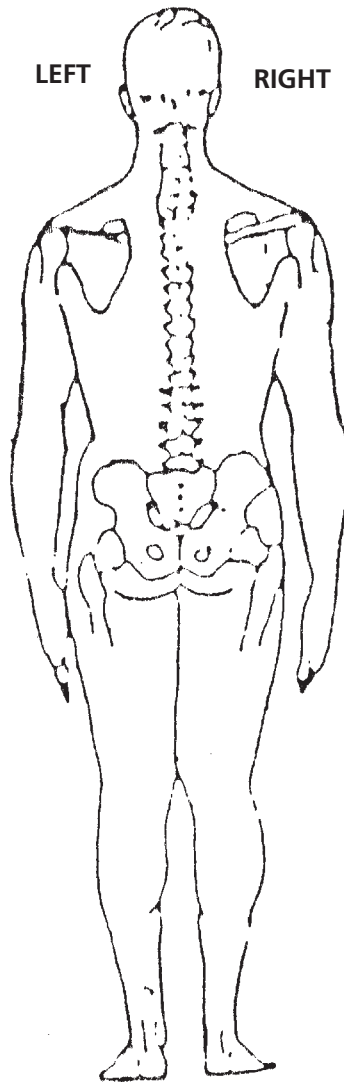
FRONT

LEFT **RIGHT**

LEFT **RIGHT**

Please complete the "Pain Diagram" by using the letters in the key below to indicate on the diagram your areas of pain.

- | | |
|------------------|------------|
| PAIN | (P) |
| TINGLING | (T) |
| NUMBNESS | (N) |
| BURNING | (B) |
| STIFFNESS | (S) |



Generally speaking, is your inability to perform daily functions due to:

- Pain Weakness Structural Limitations Nerves

Patient's Signature: _____

Date: _____