ATLANTIC CHIROPRACTIC

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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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:?

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

☐ Other (Explain) _____

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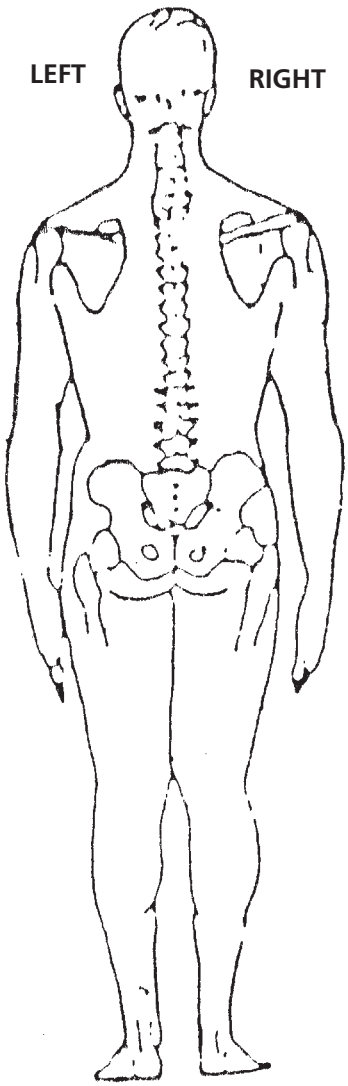
PAIN DIAGRAM

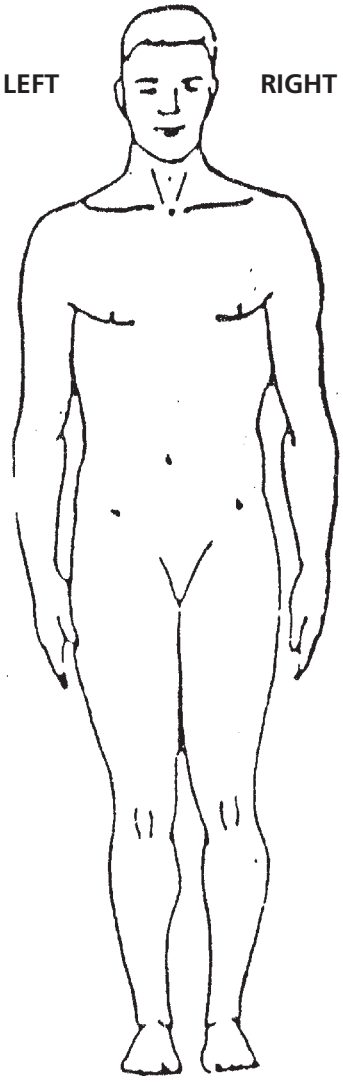
Please complete the "Pain Diagram" by using the letters in the key below to indicate on the diagram your areas of pain.

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

BACK



FRONT



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

☐ Pain ☐ Weakness ☐ Structural Limitations ☐ Nerves

Patient's Signature: _____ Date: _____