COLLARD CHIROPRACTIC & ACUPUNCTURE

AUTOMOBILE ACCIDENT QUESTIONNAIRE

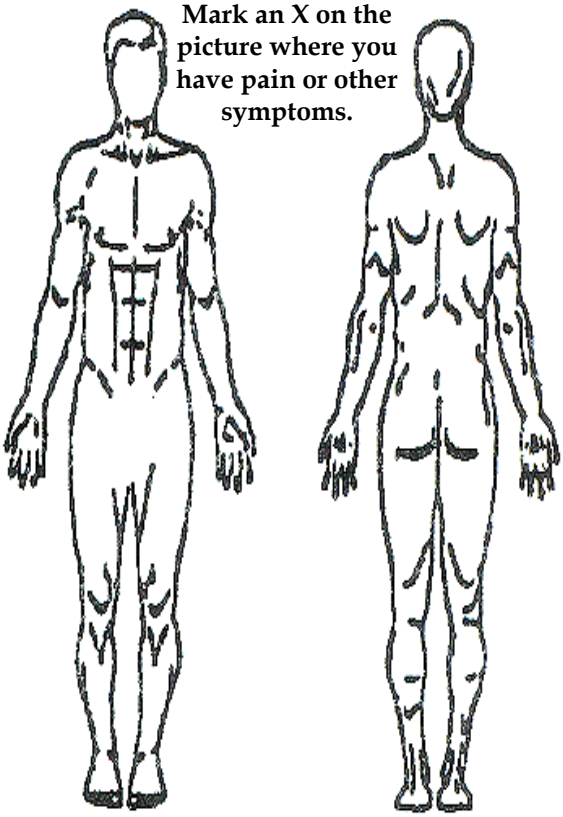
Patient: _____ Date: _____
Social Security No.: _____-_____-_____ Date of Birth: _____ Age: ____ Sex: M F
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Is it ok to text this phone? Y N
E-mail address _____ Marital Status: _____
Employer: _____Address: _____
Name of Spouse _____ No. of Children: _____
Spouses Employer: _____Address: _____

How did you learn of this clinic? _____ If referred who referred you? _____

Please explain in detail how your accident happened? _____
_____
_____

Name of driver of vehicle in which you were injured (self or other) _____
Insurance Company _____ address _____ Phone No: _____
Claim No. _____ Policy No. _____
Name of Person who has made contact with you _____
Have you retained an attorney? □ Yes □ No □ Not Yet
If so, his/her name, address & phone # _____
When did the accident happen? time: _____ □ AM □ PM _____/_____/_____
You were heading? □ North □ South □ East □ West on _____(street or highway)
Number of people in your vehicle? _____ Were police notified? □ Yes □ No
Did head strike windshield or object? □ Yes □ No
Were you knocked unconscious? □ Yes □ No If so, for how long _____
You were struck from? □ Behind □ Front □ Left side □ Right side
You were? □ Driver □ Passenger □ Back seat
Were you wearing seat belt? □ Yes □ No □ Air bags deployed □ Car seat/booster
Did you feel pain immediately after the accident?
□ Yes □ No □ Latter that day □ Next day □ Other _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was treatment given? □ Yes □ No explain: _____
Was any doctor consulted after the accident? □ Yes □ No
If so, give doctor's name _____ □ D.C., □ M.D., □ D.O., □ D.D.S
Doctor's Diagnosis _____
What treatment was given? _____
How often did you see the doctor? _____ How long did you see the doctor? _____
Have you ever had any complaints in the involved area before? □ Yes □ No
If so, what were the complaints? _____
Before the injury, were you capable of working on an equal basis with others your age? □ Y □ N
Are your work activities restricted as a result of this accident? □ Yes □ No
Since the injury, are your symptoms □ Improving? □ Getting worse? □ The same?

Patient: _____
Date: _____



Please Check all of the following that apply to

GENERAL HEALTH

□ Recent Fever
□ Diabetes
□ High Blood Pressure
□ Corticosteroid Use
□ Taking Birth Control
□ Numbness in Groin/ Buttocks
□ Osteoporosis
□ Epilepsy/Seizures
□ Prostate problems
□ Menstrual problems
□ Urinary problems
□ Pain at Night

□ Sinus
□ Allergy _____
□ Stroke (date) _____
□ Cancer/Tumor _____
□ Abnormal Weight □Gain □Loss
□ Pain unrelieved by position or rest
□ Currently Pregnant #weeks_____

□ Surgeries _____
_____
□ Medications: _____
_____
□ Other Health Problems
_____

Family History:
□ Cancer
□ Rheumatoid Arthritis
□ Diabetes
□ Heart Problems/Stroke

MUSCULO SKELETAL SYSTEM

□ Low back pain
□ Mid back pain
□ Pain between shoulders
□ Neck pain
□ Knee
□ Ankle
□ Elbow
□ Wrist
□ Spasms
□ Shoulder pain
□ Jaw pain

NERVOUS SYSTEM

□ Numbness
□ Loss of feeling
□ Paralysis
□ Dizziness
□ Fainting
□ Headaches
□ Migraines
□ Forgetfulness
□ Confusion
□ Depression
□ Insomnia

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as His/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____Parent/ Guardian's Signa-

Doctors Signature: _____Date:_____

Dr. Chad Lynn Collard D.C.

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