COLLARD CHIROPRACTIC & ACUPUNCTURE

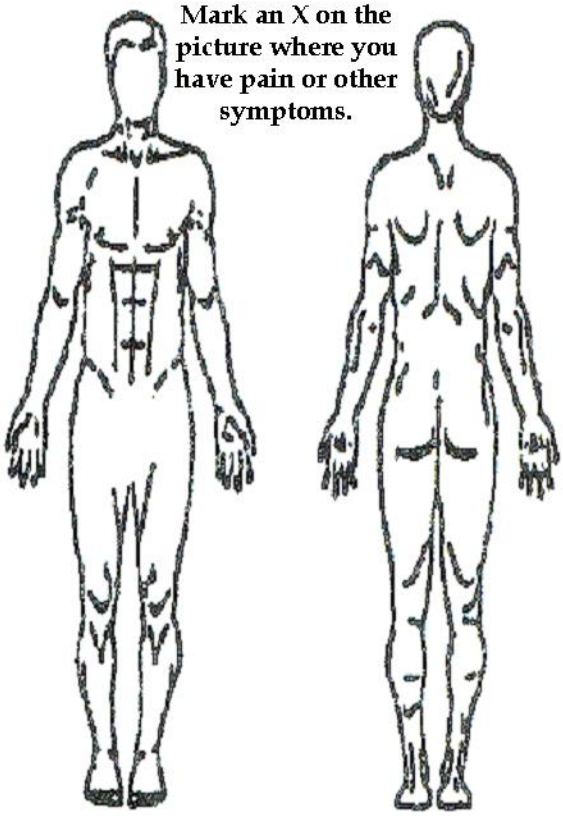
AUTOMOBILE ACCIDENT QUESTIONNAIRE

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 Signature:_____

Doctors Signature: _____Date:_____

Dr. Chad Lynn Collard D.C.

9103 South 1300 West #101 West Jordan, Utah 84095 office 801.569-1141
www.collardchiropractic.com

1. What was the date of the accident?_____

2. What time did the accident occur?_____

3. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occured?
_____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe
_____

11. Where were you sitting in the vehicle during the accident?
_____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (circle all that apply)
- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please
describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totalled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43
_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?
_____