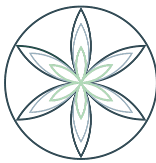

Live Empowered Chiropractic LLC

**Auto Accident Questionnaire**

Name: ______________________________ Phone: ____________________________

Address: ____________________________ City: ______________ State: ________ Zip: _______

Your Ins. Co: ___________________________ Policy #: ______________________________

Have you filed a claim with YOUR policy? Yes No Claim #: ____________________________

Adjuster Name: __________________________ Adjuster Phone: _________________________

Responsible Party's Name: ________________________ Claim #: _________________________

Address: ____________________________ City: ______________ State: ________ Zip: _______

Policy Holders Name: ____________________________Claim #: _________________________

Adjuster Name: __________________________ Adjuster Phone: _________________________

**ATTORNEY**

Name: ____________________ Phone: ______________ Fax/Email: ____________________

Address: ____________________________ City: ______________ State: ________ Zip: _______

**NATURE OF ACCIDENT**

1. Date of Accident: _______________________________ Time of Accident: _______________
2. Were you: Driver Passenger Front Seat Backseat
3. Number of People in Vehicle: _______ Were you wearing seatbelts? Yes No
4. What direction were you headed? North South East West
5. What direction was the other vehicle headed? North South East West
6. Were you struck from: Behind Front Left Right
7. Approximate speed of your car? ________mph Speed of the other car? _______mph
8. Were you knocked unconscious? Yes No If yes, for how long: ___________
9. Were the police notified? Yes No
10. In your own words, please describe the accident:____________________________________

_____________________________________________________________________________

_____________________________________________________________________________

11. Did you have any physical complaints before the accident? Yes No (If yes, please describe:)

_____________________________________________________________________________

_____________________________________________________________________________

12. Please describe how you felt:

a. DURING the accident: ___________________________________________________

b. IMMIDIATELY AFTER the accident: ________________________________________

c. LATER THAT DAY: _______________________________________________________

d. THE NEXT DAY: ________________________________________________________

13. What are your PRESENT complaints and symptoms?______________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

14. Do you have any congenital (from birth) factors which relate to this problem? Yes No
If YES, please describe:

__________________________________________________________________

15. Do you have any previous illnesses which relate to this accident? Yes No

If YES, please describe:

__________________________________________________________________

16. Have you ever been involved in an accident before? Yes No

If yes, please describe, including dates and types of accidents, as well as injury(ies) received:

_____________________________________________________________________________________

_____________________________________________________________________________________

17. Where were you taken after the accident?

_______________________________________________

18. Have you been treated by another doctor since the accident? Yes No
If yes, please list the doctors name and address:

_____________________________________________________________________________________

What type of treatment did you receive?

_____________________________________________________________________________________

19. Since this injury occurred, are your symptoms Improving Getting Worse Unchanged

20. CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

| | | | | |
|---|---|---|---|---|
| Headaches | Irritability | Numbness in Toes | Face Flushed | Feet Cold |
| Neck Pain | Chest Pain | Shortness of Breath | Buzzing in Ears | Hands Cold |
| Neck Stiff | Dizziness | Loss of Balance | Stomach Upset | Fatigue |
| Depression | Fainting | Hands seem too Heavy | Sleep Problems | Constipation |
| Back Pain | Loss of Smell | Pins/Needles in Arms | Light Bothers Eyes | Cold Sweats |
| Nervousness | Loss of Taste | Pins/Needles in Legs | Loss of Memory | Fever |
| Tension | Ears Ringing | Numbness in Fingers | Diarrhea | |

other than above: _____________________________________________________________

21. Have you lost time from work as a result of this accident? Yes No

If yes, please complete this question.

a. Last day worked: _____________________________________________
b. Type of employment: __________________________________________
c. Present Salary: ______________________________________________
d. Are you being compensated for lost time from work? Yes No If yes, please state type of compensation you are receiving: _____________________________________________

22. Do you notice any restrictions as a result of this injury? Yes No If yes, please describe:

_____________________________________________________________________________________

23. Other pertinent information: __________________________________________________________

**Print Name:** ______________________________ **Sign & Date:** _______________________________