Plasker Chiropractic & Functional Neurology

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. CHECK 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

Symptoms 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: _____**