Neeman Chiropractic
"THE POWER THAT MADE THE BODY, HEALS THE BODY"

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Date:_____

Name: _____Age_____ Birthdate_____

Address: _____City: _____State: _____ Zip:_____

Home Phone:_____Work:_____Cell:_____E-Mail_____

Social Security #_____Check One: ___Married ___Single ___Widowed ___Divorced ___Separated

Sex: M____ F____ Age of Children:_____Referred by:_____

Employer: _____Occupation:_____Hours:_____

Spouse Name:_____Employer:_____Occupation:_____

FINANCIAL DATA

Driver of other vehicle:_____

Insurance Co.:_____Policy#:_____Claim#:_____

Driver of vehicle in which you were injured:_____

Insurance Co.:_____Policy#:_____

Name of your adjuster:_____Claim#:_____

Private Health Insurance Co.:_____Policy#:_____

Have you retained an attorney? Yes____No____

If Yes - Attorney Name: _____Phone:_____

Address: _____City: _____State: _____ Zip:_____

ACCIDENT HISTORY

Date of accident:_____ Time of accident:_____AM - PM City_____

Were the police notified? Yes____ No____

Please describe in detail how the accident happened:_____

_____

_____

_____

_____

_____

You were heading: North____ East____ South____ West____ on_____ (Street or highway)

Other vehicle was headed: North____ East____ South____ West____ on_____ (Street or highway)

You were struck from: Behind_____ Front_____ Left side_____ Right side_____

You were: Driver_____ Passenger_____ Front seat_____ Back seat_____

Road conditions at the time of the accident Wet_____ Dry_____ Icy_____ Other_____

Esimated speed at impact: Other driver_____ Your vehicle_____

Your Vehicle: Make_____ Model_____ Year_____

Vehicle Size: Luxury____ Fullsize____ Midsize____ Sport____ Compact____ Sub-Compact____ 2-door____ 4-Door____

Were you aware of the approaching collision? Yes____ No____

What attempts were made to avoid the collision? (if applicable)_____

_____

_____

If your vehicle was stopped at the time of the impact, was the driver's foot also on the brake? Yes____ No____

If you vehicle was moving at the time of impact, was it:

Slowing down_____ Gaining speed_____ or Traveling at constant speed_____ ?

Were you wearing a shoulder / lap seatbelt? Yes____ No____

As best you can recall, where is your headrest on top of the seatback positioned in relation to your head? (please circle one)

Below base of head Base of head Midway of head Even with top of head Above the top of head

Do you recall striking any part of you body against any part of the interior of the vehicle? Yes____ No____

If yes, please explain_____

_____

_____

Is there any additional information regarding the accident itself that we need to be aware of? If yes, please explain

_____

_____

_____

_____

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INITIAL INJURIES HISTORY

Were you aware of any symptoms or injuries right after the accident? Please explain_____

_____

_____

If not immediately, how long was it before you noticed any symptoms?_____

_____

_____

Since this injury are your symptoms improving, getting worse or staying the same?_____

_____

_____

Did you lose consciousness (black out) upon impact? Yes____ No____ if yes how long?_____

Is there any additional information about your initial injuries that you would like to share?_____

_____

_____

TREATMENT HISTORY

Were you taken to the hospital following your accident? Yes____ No____ if yes, what hospital_____

Were you taken there via ambulance Yes____ No____ if yes, were any special measures taken_____

_____

What treatment was given at the hospital?_____

_____

What was the diagnosis given?_____

_____

Were there any special recommendations given?_____

_____

Was any other doctor consulted following your accident? Yes____ No____ if yes, what was the doctor's name_____

_____

What diagnosis and treatment was given?_____

How often did you see the doctor?_____

Have you had any previous injuries or complaints in the involved areas before? if yes, please explain_____

_____