BARATTA HOLISTIC CENTER

"A Whole New Approach To Healthcare"

AUTO ACCIDENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Home Phone: _____

Email: _____

Sex ☐M ☐F Age: _____ Birthday: _____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered

Employer/School: _____

Occupation: _____

Spouse's Name: _____

Spouse's Employer: _____

Spouse's Occupation: _____

IN CASE OF AN EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Contact Number: _____

Who may we thank for referring you? _____

ABOUT YOUR ACCIDENT

Date of accident: _____ Time: _____ Driver: _____

Where were you seated? ☐Driver ☐Passenger ☐Rear Driver ☐Rear Passenger ☐Rear Middle

Who owns the car: _____

Year, make and model of the vehicle: _____

What was the approximate damage done to the vehicle? _____

_____

Visibility at the time of the accident was: ☐Poor ☐Fair ☐Good ☐Other: _____

Road conditions at the time of accident: ☐Icy ☐Wet ☐Clear ☐Dark ☐Other: _____

Type of accident: ☐Head on collision ☐Broad-side collision ☐Front impact

☐Rear-ended by vehicle ☐Rear-ended car in front ☐Non-collision

Describe in your own words what happened to you upon impact: _____

_____

Did you see it coming? ☐YES ☐NO

Did you brace on impact? ☐YES ☐NO

Did you have your seatbelt on? ☐YES ☐NO

Were shoulder harness worn? ☐YES ☐NO

Does your car have headrests? ☐YES ☐NO

If *yes*, then what was the position of those headrests compared to your head before the accident?

☐Top of headrest even with bottom of head ☐Top of headrest even with top of head ☐Top of headrest even with middle of neck

Was your car braking? ☐YES ☐NO

Was your car moving at the time of the accident? ☐YES ☐NO

If *yes*, how fast would you estimate you were going? _____ MPH

How fast would you estimate the other car was going? _____ MPH

Head/Body position at the time of impact: ☐Head turned ☐Left ☐Right ☐Head looking back ☐Head straight forward

☐Body straight sitting position ☐Body rotated LEFT/RIGHT ☐Other: _____

At the time of the accident, recall what parts of your head hit what parts on the inside of the car: _____

_____

As a result of your accident you were: ☐Rendered unconscious ☐Dazed, circumstances vague ☐Other: _____

Could you move all parts of your body? ☐YES ☐NO

Could you move all parts of your body? ☐YES ☐NO

If *no*, what parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? ☐YES ☐NO

If *not*, why? _____

Did you get bruises? ☐YES ☐NO

If *yes*, where are they located and how long, in inches? _____

Please describe how you felt:

Immediately after the accident: _____

Later that day: _____
The next day: _____

Check the symptoms apparent since the accident:

☐Headaches ☐Neck pain ☐Mid back pain ☐Eye sensitive to light ☐Dizziness
☐Loss of smell ☐Fatigue ☐Loss of taste ☐Numbness in fingers ☐Irritability
☐Tension ☐Short of breath ☐Loss of balance ☐Cold hands ☐Cold feet ☐Diarrhea
☐Constipation ☐Chest pain ☐Nervousness ☐Cold Sweats ☐Anxious ☐Pain behind the eyes
☐Fainting ☐Depression ☐Loss of memory ☐Ringing in ears ☐Numbness in toes ☐Sleeping problems

Have you missed time from work? ☐YES ☐NO
Did you seek medical help immediately after the accident? ☐YES ☐NO
If *yes*, how did you get there? ☐Ambulance ☐Someone drive me ☐Drove my own car ☐Police ☐Other: _____
Doctor #1 Name: _____
Date of visit: _____ to _____
Were you examined? ☐YES ☐NO
Were x-rays taken? ☐YES ☐NO
Did you receive treatment? ☐YES ☐NO
If *so*, what kind of treatment: _____
Did you benefit from the treatment? ☐YES ☐NO
Date of last treatment: _____
Doctor #2 Name: _____
Date of visit: _____ to _____
Were you examined? ☐YES ☐NO
Were x-rays taken? ☐YES ☐NO
Did you receive treatment? ☐YES ☐NO
If *so*, what kind of treatment: _____
Did you benefit from the treatment? ☐YES ☐NO
Date of last treatment: _____

ATTORNEY INFORMATION

Do you have an attorney? ☐YES ☐NO
If so, who? Name:
_____
Address: _____City: _____ State: _____ Zip: _____
Phone: (____) _____ Fax: (____)
_____

The above answers are the honest answers and the best ones to my knowledge.

Signature of client: _____ Date: _____

Signature of Chiropractor: _____ Date: _____