WOOSTER CHIROPRACTIC CLINIC
Accidental Injury Questionnaire

Patient's Name: _____ Date: _____
Date of Injury: _____ Hour: _____ AM/PM
Location of Accident: _____
Road Conditions: _____

About the Accident

Were you: ❑ Driver ❑ Passenger (Front/Rear) ❑ Pedestrian
Were you wearing a seatbelt? ❑ Yes ❑ No
Were you struck from: ❑ Behind ❑ Front ❑ Driver Side ❑ Passenger Side
Did your vehicle strike another vehicle? ❑ Yes ❑ No
Did the other vehicle strike your vehicle? ❑ Yes ❑ No
Approximately how fast was your vehicle traveling at the time of the collision? _____ mph
Approximately how fast was the other vehicle traveling at the time of the collision? _____ mph
In what type of vehicle were you? (make/model) _____
What type was the other vehicle? (make/model) _____
Was a police report filed? ❑ Yes ❑ No
Were citations issued to: ❑ You ❑ Your Driver ❑ Other Vehicle

About Your Injuries

Check Symptoms You Have Noticed Since the Accident:

❑ Headache	❑ Irritability	❑ Shortness of Breath	❑ Facial Pain
❑ Neck Pain	❑ Chest Pain	❑ Fatigue	❑ Loss of Balance
❑ Neck Stiff	❑ Dizziness	❑ Depression	❑ Fainting Spells
❑ Sleeping Problems	❑ Nervousness	❑ Light Bothers Eyes	❑ Loss of Smell
❑ Head Seems Heavy	❑ Ears Ringing	❑ Loss of Memory	❑ Loss of Taste
❑ Pins & Needles in Arms	❑ Fever	❑ Stomach Upset	❑ Constipation
❑ Pins & Needles in Legs	❑ Back Pain	❑ Numbness in Fingers	❑ Diarrhea
❑ Feet Cold	❑ Hands Cold	❑ Numbness in Toes	❑ Other: _____

Did you loose consciousness during the accident? ❑ Yes ❑ No
Did your head strike any objects during the accident? ❑ Yes ❑ No
If yes, please explain: _____
In what position was your head at the time of the collision? ❑ Forward ❑ Left ❑ Right ❑ Up ❑ Down
Were you aware that the collision was going to occur? ❑ Yes ❑ No
Did you go to the emergency room after the accident? ❑ Yes ❑ No
If yes, where: _____
Have you received any treatment since the accident? ❑ Yes ❑ No
If yes, where: _____
Type of Treatment: _____

Previous Injuries

Have you been in any previous automobile accidents? ❑ Yes ❑ No

If yes, when: _____

Have you ever complained of similar symptoms? ❑ Yes ❑ No

If yes, please explain: _____

_____

Have you missed any days from work since this accident? ❑ Yes ❑ No

Insurance Information

Name of your insurance company: _____

Name of insurance company of person responsible for injuries: _____

Have you been contacted by the insurance company or adjuster? ❑ Yes ❑ No

Have you contacted an attorney to advise you on this case? ❑ Yes ❑ No

Attorney Name: _____ Phone #: _____

Attorney Address: _____

Patient's Signature: _____ Date: _____

For Doctor's Use Only

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