CRAIG D. COOK, D.C.

PROCARE SPORTS CHIROPRACTIC

PATIENT INFORMATION

VEHICLE ACCIDENT QUESTIONNAIRE

Name:_____ Today's Date:_____

1. Date of Accident: _____ Time of Accident: _____a.m □ p.m □

2. Your Vehicle was a: car □ van □ light truck □ motorcycle □ other□:_____

3. Year & Model of your vehicle: _____

4. Other vehicle was a: car □ van □ light truck □ motorcycle □ other□:_____

5. Year & Model of the other vehicle:_____

6. Which seat were you in? Driver □ R-Front □ M-Front □ R-Rear □ M-Rear □ L-Rear □

7. Were you wearing a seatbelt? No □ Shoulder only □ Lap only □ Shoulder & Lap □

8. Number of people in your vehicle: _____ Were there any witnesses? Yes □ No□

9. Was your vehicle moving? Yes □ No□ If yes, how fast was your vehicle moving?_____

10. Was the other vehicle moving? Yes □ No□ If yes, how fast was your vehicle moving?_____

11. What direction was your vehicle heading? North □ South □ East □ West □

12. What direction was the other vehicle heading? North □ South □ East □ West □

13. Where was your vehicle hit (be specific)? Rear □ Front □ Left □ Right □

14. Position at time of impact:
Head turned L/R □ Body straight/sitting □ Head looking straight □ Body rotating L/R □

15. Your position at time of impact:
Unprepared □ Braced for impact □ Holding steering wheel □ Head leaning on headrest □ Stepping on break □

16. Did any part of your body (head, knee, etc.) hit anything in the vehicle (window, steering wheel, roof, etc.)?:_____
_____

17. Please briefly describe how the accident happened in your own words:_____
_____

18. Did you suffer any bruises and/or cuts? Yes □ No □ If yes, please describe:_____
_____

19. Please describe how you felt:
Immediately after the accident:_____
Hours after the accident:_____
Next day after the accident:_____

VEHICLE ACCIDENT QUESTIONNAIRE CONT.

20. When did your current symptoms develop?_____
Immediately □ Hours Later □ Next Day □ First week □ Over the next few weeks □ Over the next few months □

21. Where did you go right after the accident?_____
Hospital □ Urgent Care □ Home □ Family Doctor □ To this Office □ Work □ Other □: _____

22. How were you taken there? Myself □ Ambulance □ Bystander □ Friend/Family □ Police □

23. <u>If you went to the hospital or treatment center, please complete the following (otherwise leave blank):</u>

Name of Clinic or Hospital: _____
Address:_____
Were you admitted? Yes □ No □
Name and type of Doctor(s) that treated you: _____
<u>Test(s) performed:</u> Examination □ X-Rays (please indicate area) □:_____ Cat Scan □ MRI □ EMG □
<u>Prescription(s) given:</u>
None □ Pain Killers □ Muscle Relaxants □ Antibiotics □ Sedatives □ Anti-inflammatory □
Cervical Collar □ Back Brace □ Other □: _____
<u>Treatment(s) given:</u> None □ Physical Therapy □ Spinal Manipulation □ Other □:_____
Did treatment help?: No, it aggravated the condition □ Yes, a little □ Yes, a lot □

24. Have you been treated by any other doctors for this injury? No □ Yes □ If yes, please complete the following:

Name and type of Doctor(s) that treated you: _____
<u>Test(s) performed:</u> Examination □ X-Rays (please indicate area) □:_____ Cat Scan □ MRI □ EMG □
<u>Prescription(s) given:</u>
None □ Pain Killers □ Muscle Relaxants □ Antibiotics □ Sedatives □ Anti-inflammatory □
Cervical Collar □ Back Brace □ Other □: _____
<u>Treatment(s) given:</u> None □ Physical Therapy □ Spinal Manipulation □ Other □:
Did treatment help?: No, it aggravated the condition □ Yes, a little □ Yes, a lot □

25. Did you have any physical complaints (pain, numbness, etc.) before this accident? No □ Yes □
If yes, please describe: _____

26. Have you ever been involved in an accident before? No □ Yes □
If yes, please describe:_____

27. Have you lost any time from work as a result of this injury? No □ Yes □
If yes, please indicate your last day worked:_____ and type of employment: _____

Date:_____ **Patient's Name:**_____

Signature of Patient (or Parent or Guardian, if minor): _____