SPECTOR CHIROPRACTIC

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name _____ Date _____

Date of Accident _____ Time of Accident _____ AM / PM

Accident occurred at _____ in/near _____
Street/Highway Location/City/State

I was (check one) ☐ the driver ☐ a passenger ☐ a pedestrian ☐ a bicyclist

I (check one) ☐ was struck by a vehicle ☐ struck a vehicle ☐ struck an object
☐ other _____

.
What part of the vehicle was struck (if applicable)? _____

Please explain how your accident happened _____

_____

_____

Road conditions at the time of the accident: ☐ **WET** ☐ **DRY** ☐ **ICE** ☐ **OTHER** _____

I became aware of being injured (check one)
☐ immediately ☐ hours later ☐ days later ☐ other _____

Did you go to a hospital? ☐ **YES** ☐ **NO**

If yes, what is the name and city of hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Have you seen any other Doctors for your injuries? ☐ **YES** ☐ **NO**

If yes, what Doctors have you seen

and what treatment did the Doctor recommend? _____

What bleeding cuts did you sustain in the accident? _____

What bruises did you sustain in the accident? _____

Where were you seated in the vehicle? _____

Where you aware of the approaching collision prior to impact, or did impact catch you by surprise?

☐ **AWARE** ☐ **SURPRISE**

Did you lose consciousness upon impact? ☐ **YES** ☐ **NO**; How Long: _____

Were you wearing a seat belt? ☐ **YES** ☐ **NO**

If yes, was it a ☐ lap seat belt ☐ shoulder-lap seat belt

Did you receive any injury or bruise from the seat belt? ☐ YES ☐ NO

If yes, then describe: _____

List the year make and model of the vehicle you were in:

year _____ make _____ model _____

Was your car stopped at the time of impact? ☐ **YES** ☐ **NO**

If yes, was the driver's foot also on the brake? ☐ YES ☐ NO
If no, estimate the speed of the vehicle you were in: _____ mph

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

slowing down? ☐ YES ☐ NO
gaining speed? ☐ YES ☐ NO
traveling at a steady rate of speed? ☐ YES ☐ NO

On what part of the inside of the automobile did your body parts hit?

head hit _____ chest hit _____
right/left shoulder hit _____ right/left arm hit _____
right/left hip hit _____ right/left leg hit _____
right/left knee hit _____ other _____

What is the estimated cost damage to the vehicle you were in? $ _____

Which of the following car parts broke during the accident?

☐ windshield ☐ front seat back
☐ right/left side window ☐ other _____
☐ steering wheel ☐ other _____

Was the trunk of your body pointed straight forward at the time of the collision?

☐ **YES** ☐ **NO**; If no, how was it turned? _____

Was your head pointed straight forward? ☐ **YES** ☐ **NO**; If no, what direction was it turned and by how much? _____

What is the year, make and model of the other vehicle?

year _____ make _____ model _____

Was the other vehicle moving at the time of the collision? ☐ **YES** ☐ **NO**

If yes, what was its approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it:

☐ slowing down ☐ gaining speed ☐ traveling at a steady speed

If your were **DRIVING SOMEONE ELSE'S VEHICLE**, answer this section completely:

Vehicle Owner's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle Owner's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

If your were **A PASSENGER** in the vehicle, answer this section completely:

Vehicle OWNER's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle OWNER's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

Vehicle DRIVER's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle DRIVER's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

If **ANOTHER VEHICLE** was involved in the collision, answer this section completely:

Vehicle OWNER's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle OWNER's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

Vehicle DRIVER's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle DRIVER's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

THE FOLLOWING INFORMATION IS REQUIRED OF ALL PATIENTS:

Your Auto Insurance Company

Name _____

Address _____

Phone# _____

Policy# _____

Purchased from _____
Agency Name, City

Your Health Insurance Company

Name _____

Phone# _____

Policy# _____

Group# _____

Employer _____

If you were **A PEDESTRIAN** or **A BICYCLIST**, answer this section completely:

Vehicle OWNER's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle OWNER's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

Vehicle DRIVER's Name

_____

Address _____

City _____ State __ Zip _____

Phone# _____

Vehicle DRIVER's Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

If you do not own a vehicle, but someone living at your permanent residence does own a vehicle, give:

Their Name _____

Their Auto Insurance Company

Name _____

Address _____

Policy# _____

Phone# _____

Has this accident been reported to the police? ☐ **YES** ☐ **NO**

If yes, please request a copy of the report for my records.

Did they come to the scene of the accident? ☐ YES ☐ NO

Did they cite anyone with a traffic violation? ☐ YES ☐ NO

Whom? ☐ myself ☐ my driver ☐ the other driver

Has this accident been reported to the insurance company? ☐ **YES** ☐ **NO**

If yes, which one(s)? ☐ my own ☐ my driver's ☐ the other driver's
☐ the owner of my driver's vehicle ☐ the other owner's

What is the claim number assigned to this accident? _____

Have you retained the services of an attorney? ☐ **YES** ☐ **NO**

If yes, Attorney's Name _____

Address _____

City _____ State _____ Zip _____

Phone# (_____)____

The information given in this questionnaire is true and accurate to the best of my knowledge.

Signed _____ Date _____

The staff of Spector Chiropractic Office appreciates your taking the time to gather this vital information. Please be assured we will do everything possible to assist you in your recovery. We will also make every effort to secure any coverage that will enable you to receive whatever care you may need.

Thank you for your cooperation.