AUTO ACCIDENT QUESTIONNAIRE

First Name __________________ M.I. _____ Last Name _______________________ Driver's License # ____________

Age ____ Date of Birth ___ - ___ - _____ Sex: Male Female Marital Status: M S D W # of children ______

Address ____ City ___________________ State _____ Zip _____________

Home Phone ( ) _____ - ___________ Work Phone ( ) _____ - __________ Cell ( ) _____ - ____________

SS# ______ - ____ - ________ Referred to our office by ____

Occupation __________________________________ Employer ____

Spouse's Name _________________ Employer _________________________ Work Phone ( ) _____ - __________

Nearest Relative or Friend ____ Phone ( ) _____ - __________

Address ____ City ___________________ State _____ Zip _____________

Your Ins. Co. ________________________________Claim # ______________________ Agent ___________________

Insurance Co. Address ____ Phone ( ) _____ - __________

Driver of other vehicle _____________________________ Ins. Co. _____________________ Policy # ______________

Date of accident ____ - ____ - ____ Time ____:____ AM PM Road conditions: Wet Dry Snow Ice

Your estimated speed: ____ mph Speed of other vehicle: ____ mph Were you wearing your seatbelt? Yes No

Was your vehicle equipped with: Headrests / Air bags (Driver Passenger Side) Did air bag(s) deploy? Yes No

How many people were in your vehicle? _____ How many people were in the other vehicle? _____

Were the police notified? Yes No Did the police come? Yes No Was a citation issued to; You Other driver None

Year, make & model of your vehicle: _________________________________ Other vehicle: ______________________

You were: Driver Passenger in: Front seat Back seat On motorcycle Did you lose consciousness? Yes No

Names of any witnesses: ____

Have you retained an attorney? Yes No Name _____________________________ Phone ( ) _____ - ________

Describe accident: ____

____

____

Describe how you felt a) during the accident:

b) Immediately after the accident:

c) Later that day or night:

d) The next day:

Where were you taken after the accident: Hospital Home Work Other ______________________________________

Have you been examined by another doctor for these injuries? Yes No Were X-rays taken? Yes No

Names of doctor(s), diagnosis, treatment, and any medications prescribed:

(continued on next page)

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List your current complaints and symptoms stemming from this accident:

Are your symptoms: Improving Getting worse Staying about the same

Have you lost time from work due to this accident? Yes No If yes, how much? ________________________________

Last day worked: __________________________ Have you returned to work? Yes No Date returned: ____________

Are you currently receiving time-loss wages? Yes No If female, are you pregnant? Yes (____ months) No Maybe

Are you having difficulty performing any daily routines? Yes No If yes, describe:

List any medications you are currently taking:

Did you have any problems before this accident? Yes No If yes, describe:

Dates and description of any previous accidents or injuries:

Surgeries (give date):

Broken bones (give date):

Circle any of the following symptoms you have had since the accident:

Headache	Irritability	Fatigue	Ringing / Pressure in the ears
Neck pain	Chest pain	Fainting spells	Dizziness / Loss of balance
Upper back pain	Head feels heavy	Loss of taste / smell	Numbness in arms / hands
Mid-back pain	Pain in arms / hands	Pain in legs / feet	Numbness in legs / feet
Lower back pain	Cold hands / feet	Nausea / Vomiting	Burred vision / Eye pain
Difficulty sleeping	Shortness of breath	Nervousness	Anxiety / Panic attacks

Forgetfulness / Difficulty remembering Diarrhea / Constipation Impotence / Erectile dysfunction

Any other symptoms:

I hereby affirm that the information I have given above is true and that I have not made any attempt to falsify my history nor misrepresent myself.

AUTHORIZATION FOR TREATMENT: I hereby authorize the doctor(s) and staff of The Spine Clinic to perform any necessary services or procedures deemed necessary to diagnose and treat my condition, and I agree to request an explanation of any procedure that I do not fully understand.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of information regarding my care at this office to my insurance company, my attorney, or any other entitled party.

AUTHORIZATION TO PAY BENEFITS: I hereby authorize direct payment to The Spine Clinic any benefits due me under any insurance policy or claim settlement as far as is necessary to cover my treatment. I understand that I am personally responsible for my bill and hereby agree to pay any amount not covered by a third party.

Signature ____ Date ______________________________

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