Desert Shadows Chiropractic and Wellness
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Motor Vehicle Accident Questionnaire

(Fill out completely; if does not apply put N/A.)

Patient Name: _____ Today's Date _____
Date of collision: ___/____/_____/ Time:_____ AM / PM
Where did the collision occur? City/Town:_____ State:_____
Please describe the collision in your own words.

_____
_____
_____
_____

Were you the: □ Driver □ Passenger □ Pedestrian
Were you wearing a seat belt? □ Yes □ No Were you wearing a shoulder Belt? □ Yes □ No
Does your vehicle have an airbag? □ Yes □ No Did it deploy? □ Yes □ No
What type of vehicle were you in? _____
What type was the other vehicle?_____
Was there a second impact? If so, explain. _____
_____
_____

Was the impact from: □ Front □ Rear □ Left Side □ Right Side
What was the approximate speed at the time of impact? Your Vehicle _____ mph
Other Vehicle_____mph
Were you going □ forward □ backward □ turning left □ turning right □ stopped
Was your foot on the brake pedal? □ Yes □ No
Were you surprised by the impact? □ Yes □ No
How much damage was there to the outside of your vehicle? □ None □ Some □ Major
To the outside of the other vehicle? □ None □ Some □ Major
Immediately after the accident, where did you experience pain? Be specific: _____
_____
_____

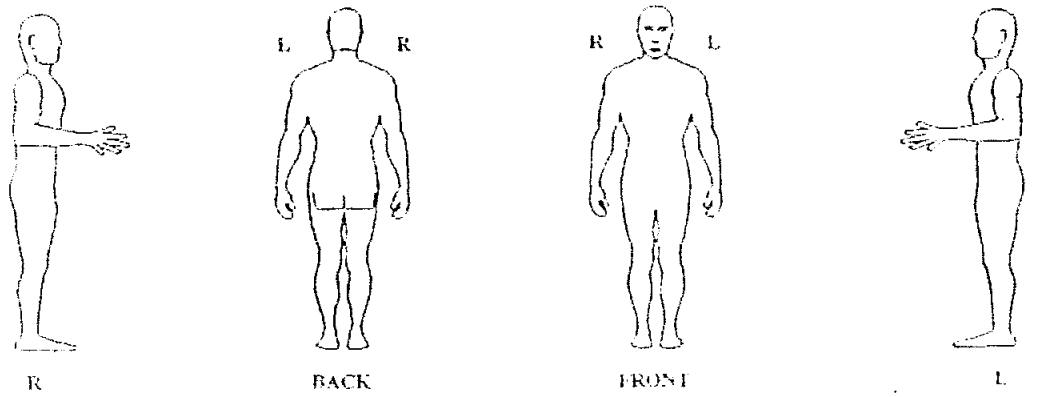
Immediately after the accident were you: □ conscious □ dazed □ unconscious
If dazed or unconscious, how long? _____
Did you strike your head? □ Yes □ No
How did you get out of the vehicle? □ On your own □ Helped out □ Taken out by someone
Did you go to the hospital? □ yes □ no If yes, how did you get there? _____
If you went to the hospital or saw another doctor, please answer the following?
Hospital Name_____ Doctor Name_____
Diagnosis_____
Treatment received_____
Tests_____
Were you admitted to the hospital? □ Yes □ No How long was your stay? _____
Were you dismissed from the ER? □ Yes □ No
Have you retained an attorney? □ Yes □ No Litigation? □ Yes □ No □ Maybe

What are your current symptoms? Please be as specific as possible.

_____
_____
_____

Areas of Complaint

Place "X's" on the areas where you have pain and draw lines to where it radiates:



Did you have any of the above complaints before your injury? Yes No

Are you experiencing any of the following since your injury? (mark all that apply)

___Headaches	___Blurry vision	___Dizziness/Loss of balance	___Digestive Problems
___Neck Pain	___Rapid heartbeat	___Blood/Lymph disorders	___Shoulder Pain
___Anxiety	___Urinary difficulties	___Indigestion	___Elbow Pain
___Fatigue	___Skin problems	___Breathing Problems	___Wrist/Hand Pain
___Sore throat	___Memory lapses	___Hot/Cold Flashes	___Upper Back Pain
___Knee Pain	___Chest Pain	___Low Back Pain	___Weight Loss/Gain
___Hip Pain	___Mid Back Pain	___Ankle/Foot Pain	

Mechanism of Injury Information

Please write a brief description of how your injury occurred _____

_____

If you injury is NOT due to an automobile collision, please skip to the section titled "Treatment Information"

Were you stopped? (Yes / No) If no, approximate speed: _____ mph

Was the other vehicle stopped? (Yes / No) If no, approximate speed: _____mph

At impact, was your body straight in your seat? (Yes / No) If no, turned to the (Left / Right)

At impact, were you looking straight ahead?(Yes / No) If no, was your head turned to the (Left/Right /Up/Down)

Were you aware that you were about to be hit? (Yes / No)

Were you wearing a seatbelt at the time of the accident? (Yes / No)

Did your (chest / head)hit the steering wheel? (Yes / No) Did an airbag deploy? (Yes / No)

Did your head hit the (Windshield / Side Window)? (Yes / No) Did your shoulder hit the door? (Yes / No)

Did your knees hit the dashboard? (Yes / No) Did the seat break? (Yes / No)

Do you have any (cuts / bruises) from the accident? (Yes / No) If yes, where?_____

Was your car equipped with headrests? (Yes / No)

If yes, at what height was the top of the headrest? (Base of head / Mid head / Top of head)

Did you lose consciousness? (Yes / No) If yes, how long _____

Treatment Information

Did you go to the Emergency Room? (Yes / No) If yes, when? _____

Name of the Hospital Emergency Room: _____

List any medications that you were given: _____

List any instructions that you were given: _____

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions / Other_____

List all the doctors that you have seen as a result of your injuries (other than at the ER):

	Date	Doctor	Treatment
1.			
2.			
3.			

Do you have any future appointments with any doctor regarding your injuries? (Yes / No)

If yes, when and with whom? _____

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Patient Signature_____ Date _____

Guardian Signature (if applicable)_____ Date_____