

**Summers Chiropractic and Massage**  
**2201 SW 356<sup>th</sup> St. Ste. A**  
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**AUTO ACCIDENT INJURY QUESTIONNAIRE**

NAME: \_\_\_\_\_ Date of Accident \_\_\_\_\_

Where did accident happen? Describe the accident in your own words:


What was your position in the car?

Driver: if Driver were your hands on the steering wheel?  Left  Right  Both

Passenger: If passenger, were you sitting in  Front  Right Rear  Left Rear

Did your vehicle strike another vehicle  Yes  No

Was your vehicle struck by another vehicle  Yes  No

Angles of impact... First Collision:  Front  Back  Left  Right

If Second Collision:  Front  Back  Left  Right

Were you wearing a seat belt?  Yes  No

Did you brace for impact?  Yes  No ...  I braced with my hands  I braced with my feet

Which way were you facing at the time of impact...  straight ahead  Left  Right

Did you strike anything in vehicle at time of impact?  Yes  No

If yes, specify what part of your body struck what: ie... head chest chin shoulder Right / Left Knee

Steering Wheel \_\_\_\_\_  Dashboard \_\_\_\_\_

Windshield \_\_\_\_\_  Roof \_\_\_\_\_

Left Side Door \_\_\_\_\_  Right Side Door \_\_\_\_\_

Left Side Window. \_\_\_\_\_  Right Window \_\_\_\_\_

Other \_\_\_\_\_

Did the seat back bend / break ?  Yes  No

Immediately following the accident, how did you feel?  dizzy/dazed  disoriented  unconscious

nervous  nauseous  upset  weak  Other \_\_\_\_\_

Did you go to hospital  Yes  No Were you admitted to the hospital?  Yes  No if yes how long? \_\_\_\_\_

If you went to hospital, when?  At time of accident  Next day

How did you get to hospital?  Ambulance  Police Car  Private Transportation

Name of Hospital: \_\_\_\_\_

Attended by Dr. \_\_\_\_\_

... what treatment was given?

none  placed in a cervical collar  x-rayed  given stitches  Bandaged

given pain medication  given instructions regarding concussions

given instructions regarding sprains and strains  Physical Therapy

instructed to call a Orthopedic Surgeon  instructed to call a private physician

referred to this office for treatment  Other \_\_\_\_\_

Have you seen any other doctor as a result of this accident?  Yes  No

Doctor's name


**CHIEF Complaints or Symptoms:**

**Name:**

**Date:**

<input type="checkbox"/> <b>Neck pain</b> check off the areas that the pain runs into from the neck	<input type="checkbox"/> none	<input type="checkbox"/> left shoulder	<input type="checkbox"/> left arm	<input type="checkbox"/> left forearm	<input type="checkbox"/> left hand
	<input type="checkbox"/> right shoulder	<input type="checkbox"/> right arm	<input type="checkbox"/> right forearm	<input type="checkbox"/> right hand	
<input type="checkbox"/> headache					
<input type="checkbox"/> Migraine Headache					
<input type="checkbox"/> upper back pain					

Ringing in Ears     Yes    No     Left     Right     Both Ears

Blurry Vision     Yes    No     Left     Right     Both Eyes

Wrist Pain     Yes    No     Left     Right     Both Wrists

Jaw Pain     Yes    No     Left     Right     Both Sides

Dizziness    nervousness    fatigue    anxiety    depression    excessive irritability

fear of driving in a car    a loss of concentration    jaw clenching    grinding of teeth at night

nightmares    difficulty with sleeping at night

<input type="checkbox"/> <b>Low Back Pain</b> select the areas of radiation, if any...	<input type="checkbox"/> none	<input type="checkbox"/> buttocks	<input type="checkbox"/> left buttock	<input type="checkbox"/> left thigh	<input type="checkbox"/> left knee
	<input type="checkbox"/> left foot	<input type="checkbox"/> right buttock	<input type="checkbox"/> right thigh	<input type="checkbox"/> right knee	<input type="checkbox"/> right foot

Hip Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral

**Numbness:**

Left Hand     Left Upper Arm     Right Hand     Right Upper Arm

Left Foot     Left Leg     Right Foot     Right Leg

**Additional Symptoms/ Complaints:**


Have You lost any time from work due to your injuries?  Yes    No

If yes please give dates: \_\_\_\_\_

Type of employment: \_\_\_\_\_

Have you had previous injuries or accidents?  Yes    No

Description of previous Accident: \_\_\_\_\_

Description of previous injuries: \_\_\_\_\_

Is there any residual pain from the previous injury?  Yes    No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) \_\_\_\_\_