Automobile Accident Questionnaire

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ Automobile Accident

When did this accident happen? _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear end ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What is the position of the headrest: ☐ Even with top of my head
☐ Even with bottom of my head
☐ Middle of neck

What inside your vehicle did you strike?

□ Airbag □ Armrest □ Center Console □ Dashboard □ Gear shift lever/knob
□ Headrest □ Rearview mirror □ Roof □ Rear window □ Seatback
□ Side door □ Side window □ Wheel □ Windshield
□ Other:_____

Immediately after the accident, did you feel dazed? □ Yes □ No

Did you lose consciousness? □ Yes □ No

Which way was your head turned during the accident?
□ Facing straight forward □ Turned to the right □ Turned to the left

Was your head injured? □ Yes □ No

Immediately after the accident, did you experience: □ Headache □ Neck Pain □ Low Back Pain

Did you see another doctor before coming here? □ Yes □ No

Did you go to a hospital after the accident? □ Yes □ No If yes, which hospital? _____

How did you get to the hospital? □ Ambulance □ Drove self □ Somebody else □ Police

Were any of the following tests performed at the hospital?
□ X-Rays □ MRI □ CT Scan □ Lab Work

Do you feel your condition is: □ Improving □ Staying the same □ Getting worse

Have you lost time from work? □ Yes □ No

Can you perform physical work activities: □ Yes □ No
If no, because of: □ Pain □ Weakness □ Stress

Can you go to sleep without problems? □ Yes □ No

Do you awaken because of pain? □ Yes □ No

Did you have sleep problems before? □ Yes □ No

Activities of Daily Living — Please select all activities which you are currently experiencing problems:

□ Seeing	□ Tasting	□ Smelling	□ Eating	□ Hearing	□ Insomnia
□ Dressing	□ Reading	□ Typing	□ Writing	□ Grasping	□ Using the toilet
□ Standing	□ Leaning	□ Walking	□ Stooping	□ Squatting	□ Loss of sexual drive
□ Bending	□ Twisting	□ Carrying	□ Lifting	□ Pushing	□ Restful sleeping
□ Sitting	□ Driving	□ Sports	□ Exercising	□ Reclining	□ Loss of concentration
□ Irritable	□ Riding in car	□ Air travel	□ Climbing	□ Pulling	□ Changes in personality
□ Grooming	□ Pinching	□ Kneeling	□ Reaching	□ Nervous	□ Tactile feeling

Attorney Information

Do you have an attorney handling this case? □ yes □ no

If yes, Name: _____ Phone: _____

Insurance Information

YOUR auto insurance: _____

Insured's name (if other than patient) _____

Phone#: _____

Address: _____City: _____State/Zip:_____

Claim #: _____Adjuster's name:_____

YOUR personal medical insurance: _____

ID #: _____Group #: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Absolute Wellness Center** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **Absolute Wellness Center** the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay **Absolute Wellness Center** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____Date:_____

Printed name: _____

AWC Witness to signature:_____