

AUTO ACCIDENT QUESTIONNAIRE



HERESCO CHIROPRACTIC
AND ASSOCIATES

Advanced Spinal Health Care

Frank Heresco, DC, DABCO
Larry Oliver, DC
Kristina Lehman, DC
Joshua Ort, DC
Kevin Ross, DC

Your Name: _____

What do you preferred to be called? _____

1. What was the date of the accident? _____

2. What time did the accident occur? _____

3. How many vehicles were involved in the accident? _____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred? _____

8. What direction were you traveling? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? If yes, please describe. _____

11. Where in the vehicle were you sitting during the accident? (example: Driver's seat) _____

12. Did you know the accident was about to happen? _____

13. What type of vehicle were you in? _____

14. If a second vehicle was involved, what type was it? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (Mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> kept going straight | <input type="checkbox"/> spun around |
| <input type="checkbox"/> kept going straight hitting a car in front | <input type="checkbox"/> spun around and hit a stationary object |
| <input type="checkbox"/> was hit by another vehicle | <input type="checkbox"/> hit a stationary object |

AUTO ACCIDENT QUESTIONNAIRE

18. Did you lose consciousness during the accident? Yes No
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? - no - yes, please describe _____
23. Did your face hit anything during the accident? - no - yes, please describe _____
24. Did your shoulders hit anything during the accident? - no - yes, please describe _____
25. Did your neck hit anything during the accident? - no - yes, please describe _____
26. Did your chest hit anything during the accident? - no - yes, please describe _____
27. Did your hips hit anything during the accident? - no - yes, please describe _____
28. Did your knees hit anything during the accident? -no - yes, please describe _____
29. Did your feet hit anything during the accident? - no - yes, please describe _____
30. What kind of headrest was in your vehicle?
 movable fixed headrest
 non-movable fixed headrest
 no headrest
31. Where was the headrest positioned on your head? High Low Other: _____
32. Did you have your seatbelt on during the accident? yes no
33. Did you slide out of your seatbelt during the accident? _____
34. What was damaged in your vehicle? (Circle all that apply)
- windshield - rear bumper - mirror
- steering wheel - front bumper - knee bolster
- dashboard - trunk - back right door
- seat frame - front left door - completely totaled
- side window - front right door
- rear window - back left door
35. Choose the items on the inside of the vehicle that dented inward:
- floorboards - side door - dashboard _____
36. Choose the doors that would not open as a result of the accident:
 front left front right all the doors worked fine
 rear left rear right
37. Did you go to the hospital? If not, why? **If not, you do not answer questions 38-43.**

38. How did you get to the hospital? _____

AUTO ACCIDENT QUESTIONNAIRE

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Mark what you were prescribed at the hospital:

- pain medication muscle relaxers neck brace told to see a chiropractor told to see your doctor
- Other _____

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x-rays taken at the hospital? If yes, which area(s) was taken? _____

Driver's Auto Insurance Information

1. Name of the driver of vehicle you were riding in? _____ Relationship or Self: _____

Driver address: _____ City: _____ State: _____ Zip: _____

2. Name of the Driver's Automobile Insurance carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Check here if this is the same as the above

Patient's Auto Insurance Information

1. Name of the Patients Automobile Insurance carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

2. Have you reported your injury to this insurance company? _____ When was it reported? _____

3. Personal Injury Claim #? _____

4. What is the adjuster's name & phone number? _____

5. Have you received an application for Personal Injury Benefits from the ins. company? _____ If so, please complete and mail ASAP.

Health Insurance Information

1. Name of your health insurance company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____

2. Name of insured: _____

3. Insured's ID #: _____ Insured's Birthday: _____ Relationship to insured: _____

Thank you so much for taking the time to complete this form.
This form will help the doctor to better serve you with your health care needs.