Hill Chiropractic Clinic

2048 West 5400 South Salt Lake City, UT 84118

ACCIDENT QUESTIONNAIRE

Name_________________________________ Date______________

Home Phone__________________ Cell _________________ Work _______________

Address____

Date of Birth: _________________ Email: ____________________________

Employer's Name____________________ Employer's Address______________________

Your Ins. Co. ___________________ Policy #___________________ Agent ___________

Claim # ______________________

Driver of Other Vehicle __________________ Ins. Co. ___________ Policy #____________

Date of Accident _______________ Time of Accident _________________ Am Pm

City of Accident _____________________ Street of Accident ________________________

Road Conditions at time of Accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other

Did the Police come to the accident scene? _______ Were you taken to the hospital? ____________

How did you get to the hospital? _________ If yes, what is the name of the hospital?__________

What type of treatment did you receive at the hospital?_________________________________

Was an MRI, CT scan or X-rays taken? ☐ Yes ☐ No If yes, what parts of your body were studied?________

____

1. Please describe, to the best of your knowledge, what happened during this accident. ______________

____

____

____

2. Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Back Seat ☐ Front Seat
3. Number of people in your vehicle?_____________ Other Vehicle? _________________
4. What direction were you headed? ☐ North ☐ South ☐ East ☐ West

   On (name of street) ______________________________
5. What direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

   On (name of street) ______________________________
6. Were you struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
7. Were you aware of the approaching collision prior to impact, or did the impact take you by surprise?

   ____
8. Did you lose consciousness/black out upon impact? ☐ Yes ☐ No How Long? _________
9. How far is the top of the headrest or seatback from the top of your head? (Approx) _____ in. Above/Below
10. Were you wearing a seatbelt ☐ Yes ☐ No If yes, then was it a ☐ lap seatbelt ☐ shoulder-lap seatbelt
11. Was the trunk of your body pointed straight forward at the time of the collision? ☐ Yes ☐ No

    If no, which direction was it turned, and by how much? __________________________

12. Was your head pointed straight forward? ☐ Yes ☐ No
    If no, which direction was it turned, and by how much? ____________________

13. On what part of the auto did the following body parts hit?
    A. Head hit ____________________
    B. Chest hit ____________________
    C. RT—LT Shoulder hit ____________________
    D. RT—LT Arm hit ____________________
    E. RT—LT Hip hit ____________________
    F. RT—LT Leg hit ____________________
    G. RT—LT Knee hit ____________________
    H. Other: ____________________

14. Did you have any physical complaints **BEFORE THE ACCIDENT**? ☐ Yes ☐ No If yes, describe in detail: ____________________

15. Please describe how you felt:
    a. **During** the accident: ____________________
    b. **Immediately After** the accident: ____________________
    c. **Later** that day: ____________________
    d. The **Next** day: ____________________
    e. **Present** complaints and symptoms: ____________________

The following questions pertain to the vehicles involved in the accident:

1. List the year, make and model of **your** vehicle: Year ________ Make ________ Model ________

2. Was your vehicle stopped at the time of impact ☐ Yes ☐ No
   If yes, was your foot on the brake? ☐Yes☐ No
   If no, then estimate the speed of the vehicle you were in ________ MPH

3. Were you: slowing down? ☐ Yes ☐ No Gaining speed? ☐ Yes ☐ No Traveling steady? ☐ Yes ☐ No

4. List the year, make and model of the **other** vehicle: Year ______ Make ______ Model ________

5. Was the other vehicle moving at the time of the collision? ☐Yes ☐ No Approximate speed ______ MPH

6. Was it: slowing down? ☐ Yes ☐ No Gaining speed? ☐ Yes ☐ No Traveling steady? ☐ Yes ☐ No

   If you have been in other auto accidents, please list the year for each:

   1. ____________________

   2. ____________________

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

Indicate for each: **M** – Mild **MO** – Moderate **S** – Severe

M	MO	S	
☐	☐	☐	Headaches
☐	☐	☐	Head and neck pain
☐	☐	☐	Tension
☐	☐	☐	Muscle Spasms
☐	☐	☐	Stiff Neck
☐	☐	☐	Restriction of neck motion
☐	☐	☐	Pain between the shoulders
☐	☐	☐	Joint pain
☐	☐	☐	General aches, pain or tension
☐	☐	☐	General stiffness
☐	☐	☐	Numbness or tingling of (Lt/Rt/B) shoulders
☐	☐	☐	Numbness or tingling of (Lt/Rt/B) arms
☐	☐	☐	Numbness or tingling of (Lt/Rt/B) hands
☐	☐	☐	Neck and shoulders feel tired
☐	☐	☐	Heaviness of head
☐	☐	☐	Cold Hands
☐	☐	☐	Fever
☐	☐	☐	Ringing in the ears
☐	☐	☐	Dizziness
☐	☐	☐	Light headedness
☐	☐	☐	Loss of balance
☐	☐	☐	Blackouts
☐	☐	☐	Earaches
☐	☐	☐	Difficulty hearing
☐	☐	☐	Loss of hearing
☐	☐	☐	Allergies/sinus problems
☐	☐	☐	Loss of Smell
☐	☐	☐	Eye Strain
☐	☐	☐	Sensitivity to light
☐	☐	☐	Night blindness
☐	☐	☐	TMJ (jaw) pain
☐	☐	☐	Difficulty Chewing
☐	☐	☐	Clicking jaw
☐	☐	☐	Pinched nerves
☐	☐	☐	Low back pain
☐	☐	☐	"Slipped" discs
☐	☐	☐	Cold feet

M	MO	S	
☐	☐	☐	Numbness or tingling of (Lt/Rt/B) Legs
☐	☐	☐	Numbness or tingling of (Lt/Rt/B) Feet
☐	☐	☐	Muscle Tearing
☐	☐	☐	Muscle Swelling
☐	☐	☐	Muscle atrophy (wasting or dying)
☐	☐	☐	Neuralgia (nerve pain)
☐	☐	☐	Loss of normal spinal contours
☐	☐	☐	Dislocations
☐	☐	☐	Fractions
☐	☐	☐	Gastrointestinal (digestive) problems
☐	☐	☐	Heartburn
☐	☐	☐	Nausea
☐	☐	☐	Bladder Trouble
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Chest Pain
☐	☐	☐	Blood pressure problems
☐	☐	☐	Palpitations (rapid heart beating)
☐	☐	☐	Irregular heartbeat
☐	☐	☐	Breathing difficulties
☐	☐	☐	Shortness of breath
☐	☐	☐	Asthma
☐	☐	☐	Fatigue (tiredness)
☐	☐	☐	Nervousness
☐	☐	☐	Tremors (shaking)
☐	☐	☐	Anxiety
☐	☐	☐	Depression
☐	☐	☐	Stress
☐	☐	☐	Mood swings or irritability
☐	☐	☐	Poor memory
☐	☐	☐	Inability to concentrate
☐	☐	☐	Insomnia (can't sleep)
☐	☐	☐	Excessive sweating
☐	☐	☐	Excessive tearing
☐	☐	☐	Increased reactions to drugs
☐	☐	☐	Pallor (pale, cold and clammy)
☐	☐	☐	Other, please describe