Rasmussen Chiropractic Center
Automobile Accident Questionnaire

Please Answer All Questions Completely

Dear patient: the information provided in this document is vital to the treatment of your injuries and to evaluate complications to any previous conditions. Please be as neat and accurate as possible while completing this form. **(Please print).** Our office has evaluated thousands of patients involved in motor vehicle accidents; we require only the necessary documents that are needed to give you the highest quality of care. (Information can be given to Doctor in private)

Last Name: _____ First Name: _____

Brief Description of Accident: _____

_____

HISTORY OF OCCURRENCE

Date of Accident: _____ Time: _____ [] AM [] PM City/Town _____

You were: [] Driver [] Passenger [] Front Seat [] Right Rear [] Middle Rear [] Left Rear [] Other

Your **vehicle** type [] car [] van [] pickup [] truck [] bus [] M. Cycle [] other **Size**: [] mini [] sub comp [] compact [] mid [] full

Action: [] stopped [] slowing [] accelerating [] cruising **Speed**: _____ (mph)

At the time of the accident **visibility** was: [] Poor [] Fair [] Good / It was: [] Day light [] Dawn [] Dusk [] Dark

Road conditions: [] Dry [] Damp [] Wet [] Snow [] Icy

IMPACT INFORMATION:

Your vehicle: [] Hit another car [] Was hit by other vehicle in the: [] Right [] Left [] Rear [] Front []Drivers Side [] Pass side

Type of accident: [] Head-on collision [] Rear-end collision [] Broadside collision [] front impact, rear- ended car in front

Describe in your own words what happened to you upon impact: _____

Other vehicle or Object: [] Car [] Van [] Pickup [] Truck [] Truck [] Bus [] SUV [] M. Cycle [] other _____

Size: [] Mini [] Sub Compact [] Compact [] Mid Size [] Full Size

Damages to Other: [] Minimal [] Moderate [] Extensive [] Totaled [] Unsure

If there was a second vehicle or object include here or skip to next section

Other vehicle or Object: [] Car [] Van [] Pickup [] Truck [] Truck [] Bus [] SUV [] M. Cycle [] other _____

Size: [] Mini [] Sub Compact [] Compact [] Mid Size [] Full Size

Damages to Other: [] Minimal [] Moderate [] Extensive [] Totaled [] Unsure

DURING IMPACT INFORMATION:

Were shoulder harnesses or **seat belt** worn? [] Yes [] No Did **Air bag** deploy? [] Yes [] No

Did your **seat back** position change? [] Yes [] No Did your vehicle have **headrests**? [] Yes [] No If yes, was it positioned properly before the accident [] Yes [] No **Headrest Position**: [] Low [] Mid [] High Was **Seat Broken**? [] Yes [] No

Was your vehicle **braking**? [] Yes [] No / Was your vehicle moving at the time of the accident? [] Yes [] No

HEAD/ BODY / POSITION / ABLE TO MOVE BODY

Were you **prepared** for the accident: [] Un-expected [] Expected [] Expected and Braced

Head position at time of impact: [] head turned: [] Right [] Left [] Looking Back [] Straightforward [] Looking up at mirror

Body position [] Straight [] Body rotated: [] Right [] Left [] I cannot remember the position I was in.

Your **head motion**? [] Forward backwards [] Backward Forwards [] Right to Left [] Left to Right [] Unsure

Did your **body get thrown**? [] Yes [] No What Direction? [] Backwards [] Forwards [] Outside [] Unsure

At the time of the accident, recall the parts of your **body** that were struck during the **impact:**

_____

AFTER ACCIDENT INFORMATION:

As a result of the accident you were: [] rendered unconscious [] dazed, circumstances vague [] Upset [] Nervous []Weak [] Disoriented shaken up but could function [] At first I thought I was ok but, I began to stiffen as time went on.

Were you able to get out of the vehicle and walk unaided [] Yes [] No If no, why not? _____

Immediately following the accident, I started having **pain** in the following areas: (also list numbness & tenderness etc.)

_____

_____

(Symptoms that started after the accident are under section titled "LATER SYMPTOMS") CONTINUE ON OTHER SIDE

MEDICAL INFORMATION: (Did you get medical care for this accident before coming to our office)
Did you go to seek medical help immediately / soon after the accident? [] Yes [] No [] At time of accident
[]Next day [] Later that day [] Days later: (specify) _____
If yes, how did you get there? [] Someone else drove me [] I drove my car [] Ambulance [] Police
Doctor/ Hospital / Clinic seen: _____ Date of first visit _____
Were x-rays taken as part of your examination? [] Yes [] No / other diagnostic tests: [] MRI [] Lab [] CT scan
[] Other (specify) _____
Were you given treatment? [] Yes [] No / if yes, what treatment? [] Ice packs [] Hot packs [] Braces or collar
[] Medications: _____ [] other (specify) _____
What benefits did you receive from treatment? _____
Other doctors seen for this injury _____ Date of last visit _____

PREVIOUS INJURIES:
Have you had any previous Injuries or accidents? [] No [] Yes (specify) _____
Is there residual pain from previous? [] No [] Yes (specify) _____
Before this injury did you have any conditions that would affect your recovery [] No [] Yes _____

LATER SYMPTOMS: (Please note any symptoms that **started after** the accident occurred)

Head: [] Headaches [] Loss of memory [] Dizziness [] Blurred Vision [] Light Headedness [] Fainting [] Pain in Ear
[] Doubled Vision [] Loss of sight [] other _____

Neck: [] Pain in Neck [] Muscle Spasm [] Popping in neck ***/ Pain with movement*** [] Forward [] Backward [] Turn Right
[] Turn left [] Bend right [] bend Left [] other _____

Shoulders: [] Pain in shoulder Joint [] Pain across shoulders [] Tension in Shoulders [] Muscle Spasms in shoulder
Can't raise Arms: [] Above Shoulder Level [] Over Head [] other _____

Arms & Hands: [] Pain in Fingers [] Numbness in Left [] Right Arm [] Pins & Needles Hand [] Pins & Needles in Fingers
[] Cold Hands [] Swollen Joints [] Loss of Grip [] Other _____

Chest: [] Chest Pain [] Pain around Ribs [] Shortness of Breath [] Breast Pain [] Other _____

Abdomen: [] Nervous Stomach [] Nausea [] Diarrhea [] Gas [] Constipation [] Other _____

Mid back: [] Sharp Stabbing [] Mid back Pain [] Pain From front to back [] Dull ache [] Muscle Spasms
[] Pain between Shoulder Blades [] Pain in Kidney Areas [] Other _____

Lower Back: [] Pain [] Muscle Spasms / ***Low back is worse when:*** [] Working [] Lifting [] Stooping [] Standing [] Sitting
[] Bending [] Coughing [] Lying Down [] Other _____

Hips, Legs & Feet: [] Pain in Buttocks [] Pins & Needles in Legs [] Pain down leg [] Pain in Hip [] Feet feel Cold [] Knee Pain
[] Numbness of Toes [] Numbness of leg [] Legs Cramp [] Cramp in Feet [] Swollen Feet

General: [] Nervousness [] Fatigue [] Irritable [] Depressed [] Generally feel rundown [] Difficulty Urinating [] Cramping
[] Night Urination [] Prostrate Pain / Swelling [] Irregularity [] Loss of Sleep _____ Hrs. per night
[] Weight Gain _____ Lbs. [] Weight Loss _____ Lbs. [] Other _____

My **overall condition** got ***worse*** later that [] Day [] Night [] the next day [] that week [] in approximate couple of weeks
My condition today is about the ***same*** overall since my symptoms started [] No [] Yes [] Not sure
Has your condition ***improved*** since the accident? [] No [] Yes, but the progress is too slow.

WORK HISTORY SINCE ACCIDENT:
Have you missed time from work? [] Yes [] No / if yes, Dates from_____ to _____
[] I have been able to work in spite of pain [] I have been unable to work since the auto accident.
[] My present condition will make my job more difficult as time goes on.

I affirm that the information stated above is true to the best of my recollection and will be used to treat
My injuries, and used as a legal document should litigation occur in this case.

Signature: _____ Date: _____
Please provide us with a copy of the police report as soon as it becomes available. Thank you.
All questions in this questionnaire are strictly confidential and will become part of your medical record.

