Balanced Body
CHIROPRACTIC MN, P.A.

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AUTO ACCIDENT QUESTIONAIRE

Date of Accident: ______________________________

Time of Accident: ______________________________

To your knowledge what caused the accident?

____

____

What occurred following the accident? (Circle all that apply)

Received emergency care   Felt confused   Felt nervous

Loss of consciousness   Felt weak   Transported to the hospital via ambulance

After accident you were taken to? ____

Position in vehicle? Driver   Front seat passenger   Back seat passenger

Were you wearing a seat belt? Yes No

Was the accident: Expected   Complete surprise

How was your vehicle struck? Front end   Rear end   Right side   Left side

Did the air bags deploy? Yes No

Did the seat break? Yes No

Did your vehicle have a headrest? Yes No

What speed were you traveling? _______________ What speed was other vehicle traveling? ____________

What type of vehicle were you in? __________________ Type of other vehicle involved?_________________

Was visibility (circle one) Poor   Good

What was the condition of the roadway? Wet Dry other: ___________________________

Where did you feel pain immediately following the accident? ______________________________________

Do you or did you have any visible abrasions? Yes No

If yes, where? ____

What type of treatment have you had since the accident? ____

____

Are you taking medication due to injuries from this accident? Yes No

If yes, what type of medication?____

____

Where x-rays or special test performed following the accident? Yes No

If yes, list name or facility where tests were performed:____

____

Do you have additional symptoms or complaints that have occurred since the accident? Yes No

If yes, please list: ____

____

Is there any additional information you would like us to know?

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