CAROLINASCHIROPRACTIC
AND SPINAL REHAB

Automobile Accident Questionnaire

Name:____Date:_______________________

1. Date of Accident: _______________________________________Time:______________ a.m./p.m.

2. Driver of car: ________________________________Where you were seated:___________________

3. Owner of car: ________________________________Year and Model of car:___________________

4. Visibility at time of accident: poor/fair/good/other: _______________________________

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _______________

6. Where was your car struck? right/left/rear/front/side/other: ____________________

7. Type of accident: ☐ head-on collision ☐ broad-side collision ☐ rear-end collision
☐ front impact, rear-ended car in front ☐ non-collision: ____________________________

8. What part of the car was damaged? ____

9. Describe what happened to you upon impact? ______________________________________

10. Did you see the accident was about to happen? ☐ Yes ☐ No

11. Did you brace for impact? ☐ Yes ☐ No

12. Were you wearing a seatbelt? ☐ Yes ☐ No

16. Was your car braking? ☐ Yes ☐ No Was the other car braking? ☐ Yes ☐ No

17. Was your car moving at the time of the accident? ☐ Yes ☐ No

If yes, how fast would you estimate you were going? _________________________________

18. How fast would you estimate the other car was traveling? __________________________

19. What was the position of your head and body at the time of impact?

☐ head turned left/right ☐ body straight in sitting position ☐ head looking back

☐ body rotated left/right ☐ head straight forward ☐ other:_______________

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:
____

____

21. As a result of the accident were you: ☐ rendered unconscious ☐ dazed ☐ other: _______________

22. Could you move all parts of your body? ☐ yes ☐ no

If no, why not? _______________

23. Were you able to get out of the car and walk unaided? ☐ yes ☐ no

If no, why not? _______________

24. Did you have any cuts or bruises from this accident? ☐ yes ☐ no

If so, where? _______________

25. Describe how you felt immediately after the accident? _______________

____

How did you feel later that ☐ day ☐ night? _______________

How did you feel the next day(s)? _______________

26. Check symptoms apparent since the accident:

☐ headache ☐ loss of smell ☐ numbness in fingers ☐ neck pain/stiffness
☐ loss of taste ☐ cold hands ☐ mid-back pain ☐ loss of memory
☐ cold feet ☐ low-back pain ☐ fatigue ☐ diarrhea
☐ tension ☐ constipation ☐ pain behind eyes ☐ shortness of breath
☐ chest pain ☐ dizziness ☐ irritability ☐ nervousness
☐ fainting ☐ depression ☐ cold sweats ☐ anxious
☐ sleeping problems ☐ loss of balance ☐ numbness in toes
☐ ringing/buzzing in ears ☐ eyes sensitive to light ☐ other:_______________

27. Have you missed time from work? ☐ yes ☐ no Work hours are: ☐ full-time ☐ part-time

If you have missed time from work, how much time have you missed? _______________

28. Did you seek medical help immediately/soon after the accident? ☐ yes ☐ no **If no, skip to #35**If yes, how did you get there? _______________

29. Doctor/hospital/clinic seen: ______________________ Date: __________

30. What was done? ______________________

Were x-rays taken? ☐ yes ☐ no If yes, of what body part? ______________________

31. What treatments/prescriptions were given? ☐ bed rest ☐ brace ☐ adjustments ☐ medications

32. What benefit(s) did you receive from treatment(s)? ______________________

____

33. Date of last treatment: ______________________

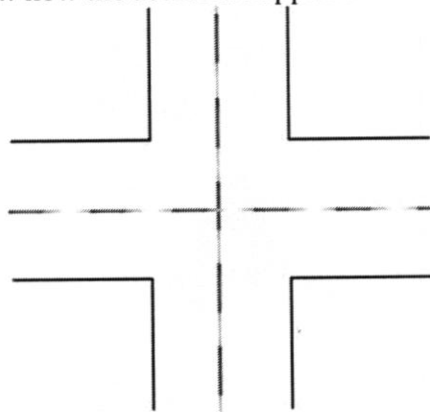
34. Are any of your activities of daily living any different now compared to before the accident?
☐ yes ☐ no

List anything you are unable to do: ______________________

List anything that is painful to do: ______________________

List anything that is difficult to do: ______________________

35. Indicate on the diagram below how the accident happened:



Comments: ______________________

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36. Do you have an attorney handling this case? ☐ yes ☐ no

If yes, who? (name/address)______________________

CAROLINASCHIROPRACTIC
AND SPINAL REHAB

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Assignment of Benefits

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Carolinas Chiropractic and Spinal Rehab any monies due on my account, the same to be deducted from any settlement made on my behalf. Furthermore, I agree to pay Carolinas Chiropractic and Spinal Rehab 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 understood that I, the undersigned, agree to pay Carolinas Chiropractic and Spinal Rehab 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 refused to pay my claim.

I authorize Carolinas Chiropractic and Spinal Rehab to place a lien on any funds received through: settlement, medication, arbitration, or litigation, pursuant to N.C.G.S. 44-49 and 44-50.1. I understand that Carolinas Chiropractic and Spinal Rehab has the right to make a claim against settlement proceeds based upon this lien, and any insurance company or attorney would be required to honor this lien before disbursing funds to me.

Patient's Signature: ______________________________ Date: ______________

Printed Name: ____