

ACCIDENT QUESTIONNAIRE

Acc Quest-pm

Please print clearly and be as accurate as possible.

Name - last _____ / first _____ / middle _____ DATE _____

Address - _____ City _____ State _____ Zip _____

Phone - home _____ work _____ cell _____

SSN - _____ / _____ / _____ Birth date - ____ / ____ / ____ Age - _____ Sex - male * female

Your employer - _____ Address _____

Your spouse's name _____ # of children _____ children's ages _____

******* INSURANCE *******

Who is paying for your services ? _____

If insurance is paying what is the insurance company name ? _____

What is their phone number ? _____ What is the claim number ? _____

Who is the adjuster ? _____

Have you talked to the adjuster ? YES NO When? _____

******* DESCRIPTION of ACCIDENT *******

Date - _____ * Time - _____ am / pm * Where _____

Describe the accident / fall / injury - _____

Did you notify anyone ? yes / no * If yes who did you notify ? _____

Were there any witnesses ? yes / no * If yes who ? _____

Did you loose consciousness ? yes / no * Did you sustain any cuts ? yes / no * Did you sustain any bruises ? yes / no

Did this injury happen while you were working for your employer? yes / no

******* Staff fills out name / date below *******

Name - _____ Date - _____

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******* PRIOR TREATMENT *******

Did you go to a hospital ? yes / no * If yes did you go by ambulance / car ? * Which hospital ? Hillcrest / Providence / _____
What was the doctor's name ? _____ / don't know * Were you xrayed ? yes / no MRI - yes / no CT- yes / no
Were you given a prescription ? yes / no * If yes what were you prescribed ? _____
Have you seen a doctor beside the ER ? yes / no * If yes who and when ? _____
What did this doctor do for you ? _____
Who is your family doctor ? _____
Have you taken anything today ? yes / no * If yes what _____
What has helped you the most ? prescription / heating pad / ointment / rest / over the counter medication - _____

******* WORK HISTORY - if you do not have a job skip this section *******

Did you have a job at the time of this injury ? yes / no * If yes where were you working ? _____
How long have you been at this job ? _____ Are you working full time / part time ? How many hours a week ? _____
Have you missed any work because of this injury ? yes / no * If yes how much time have you missed ? _____
Who took you off work ? the hospital / a doctor / yourself / _____
Have you returned to work as of today ? yes / no * If yes are you doing your same job duties as you were before this injury ? yes / no
What are your job duties ? _____

******* FILL THIS OUT IF YOU WERE IN A MOTOR VEHICLE ACCIDENT *******

What kind of vehicle were you in ? car / truck / SUV _____ What year was your vehicle ? _____ / don't know
Where were you in the vehicle ? driver / front seat passenger / back seat passenger * What hit you ? car / truck / SUV _____
Where was your vehicle hit ? head on / rear ended / left -- right side * How much damage was done to your vehicle ? \$ _____
How many people in your vehicle at the time of the accident including yourself ? _____
Were you wearing a ? seatbelt - yes / no shoulder strap - yes / no * Did your airbag deploy ? yes / no / didn't have one _____

******* AFFECTS OF THIS INJURY *******

Has this injury affected your interaction with your family ? yes / no With any of your hobbies ? yes / no
Have you stopped doing anything because of your symptoms ? yes / no * If yes what ? _____
Were you exercising before this injury ? yes / no * If yes what were you doing ? weights - walking - running - _____
Are you still exercising ? yes / no * If no why ? _____

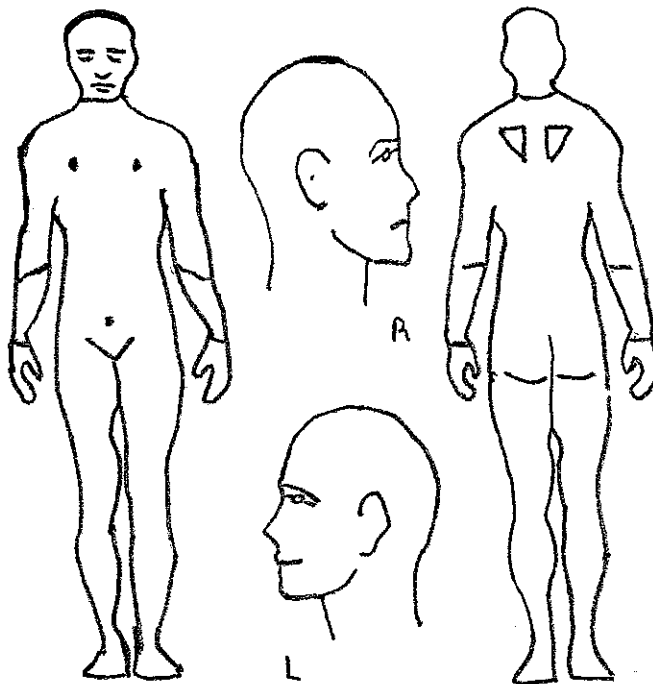
******* Staff fills out name / date below *******

Name - _____ Date - _____

***** SYMPTOM HISTORY *****

Please describe your symptoms / complaints: _____

Please mark your symptoms resulting from this injury / accident on the figures below .



Since your injury / accident have your symptoms : improved / are improving / the same / getting worse

IF APPLICABLE ARE YOU PREGNANT ? YES / NO If yes how many weeks along are you ? _____ When is your due date? _____

If pregnant who is your OB? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

***** Staff fills out name / date below *****

Name - _____ Date - _____

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Patient - please circle the activities listed below that your symptoms are affecting or interfering with.

bathing / grooming / dressing / eating / going to the bathroom / self care / personal hygiene / hearing / speaking / reading / writing / using a keyboard / using a mouse / using a phone

standing / sitting / walking / reclining / stooping / squatting / kneeling / reaching / bending / twisting / leaning / carrying / lifting / pushing / pulling / climbing / exercising / seeing / tasting / smelling / touching / grasping / holding / pinching / percussive movements / riding / driving

traveling by airplane - car - train / participating in sexual activity / having restful sleep / participating in individual or group activities / sports / hobbies / interacting with your kids

^^^^^^ Patient - please circle the level of pain you have today ^^^^^^^

0 = no pain

1-2 = annoying pain that you forget during daily activities

3-4 = pain that interferes with SOME of your activities

5-6 = pain that PREVENTS some of your activities

7-8 = pain that PREVENTS most of your activities

9 = the most severe pain you can withstand but you know or believe it is only temporary

10 = the most severe pain that you can withstand but you don't know or believe it will go away

^^^^^^ Circle the amount of time you have your symptoms ^^^^^^^

CONSTANT - 76% - 100% of the time you are awake - all day

FREQUENT - 61% - 75% of the time you are awake - 3/4 of the day

INTERMITTENT - 26% - 50% of the time you are awake - half of the day

OCCASIONAL - 1% - 25% of the time you are awake - 1/4 of the day or less

***** EMERGENCY CONTACT *****

Name _____ Phone _____

Address _____

Relationship _____

By my signature below I attest that my answers to these questions are correct and accurate.

Signature _____ Date _____

***** Staff fills out name / date below *****

Name - _____ Date - _____