Reservoir of HEALTH 203-929-5700

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determir chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept y case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing i form. Thank you.

Patient Details (Please use print)

Name				Contact Ph:			
Address		City		State		Zip	
Married		Sex		DOB			
Occupation		Who referred you?					

(please indicate if child, student, housewife, unemployed, retired)

Social Sec.#	Business Phone	Company Name	Location
Spouses First Name	Spouses Social Sec.#	Spouses Employer	Location

Please explain in detail how your accident happened:	

Insurance Company:		
Policy No.:		Claim No.:
Driver of other vehicle (if any)		
Insurance Company:		Policy No.:
Driver of vehicle in which you were injured (if applicable):		
Insurance Company:		Policy No.:
Name of insurance adjuster:		

Have you retained an attorney? [ ] Yes [ ] No

If so, his name, address and telephone: _____

_____

1077 Bridgeport Ave, Shelton, CT 06484 Ph: 203-929-5700 Fax: 203-929-5600

Accident Details

You were heading [ ] North [ ] East [ ] South [ ] West on _____ (street or highway)
Other vehicle was headed [ ] North [ ] East [ ] South [ ] West on _____ (street or highway)
Were police notified? [ ] Yes [ ] No
Were you knocked unconscious? [ ] Yes [ ] No If so, for how long?_____
You were struck from [ ] Behind [ ] Front [ ] Left side [ ] Right side
You were [ ] Driver [ ] Passenger [ ] Front seat [ ] Backseat [ ] Using seat belts [ ] Other protective devices
What were the time and date of present injury? _____
Where did you feel pain immediately after the accident? . _____
Where were you taken after the accident? _____
What treatment was given?_____
_____

Was any other doctor consulted after your accident? [ ] Yes [ ] No
If so, what was the doctor's name?———————————————————— [ ] D.C., [ ] M.D., [ ] D.O., [ ] D.S

What was the diagnosis?_____
_____
_____

What treatment was given?_____
_____
_____

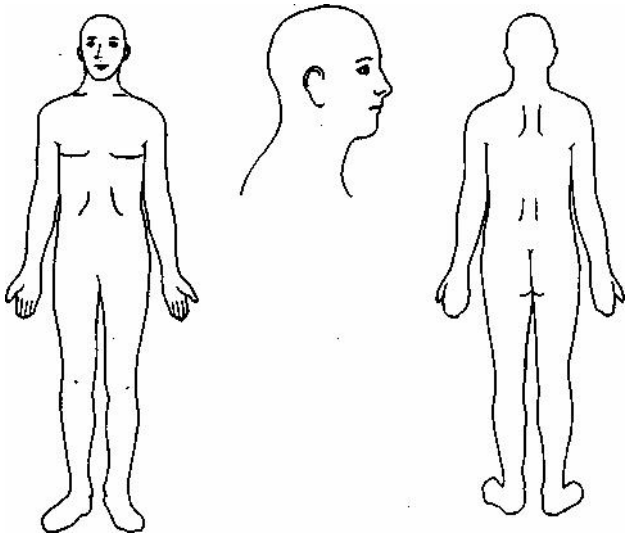
How often did you see the doctor? _____
How long did you see the doctor? _____
Have you ever had any complaints in the involved area before? [ ] Yes [ ] No
If so, what were the complaints? _____
Before the injury were you capable of working on an equal basis with others your age? [ ] Yes [ ] No
Are your work activities restricted as a result of this accident? [ ] Yes [ ] No
Since this injury are your symptoms [ ] Improving? [ ] Getting worse? [ ] Same?
Other information: _____
_____
_____
_____
_____
_____
_____
_____
_____

1077 Bridgeport Ave, Shelton, CT 06484 Ph: 203-929-5700 Fax: 203-929-5600

Health Questionnaire

Please indicate for each of the questions below your experience by use of the following codes:
1—never had; 2—previously had; 3—presently have.

MUSCULO-SKELETAL SYSTEM		GENITO-URINARY SYSTEM		GASTROINTESTINAL SYSTEM		CARDIO-VASCULAR-RESPIRATORY	
	Low back problems		Bladder trouble		Poor appetite		Chest pain
	Pain between shoulders		Excessive urination		Excessive hunger		Pain over heart
	Neck problems		Scanty urination		Difficult chewing		Difficult breathing
	Arm problems		Painful urination		Difficult swallowing		Persistent cough
	Leg problems		Discolored urine		Excessive thirst		Coughing phlegm
	Swollen joints	**FEMALE**			Nausea		Coughing blood
	Painful joints		Vaginal discharge		Vomiting food		Rapid heartbeat
	Stiff joints		Vaginal bleeding		Vomiting blood		Blood pressure problems
	Sore muscles		Vaginal pain		Abdominal pain		Heart problems
	Weak muscles		Breast pain		Diarrhea		Lung problems
	Walking problems		Lumps on breast		Constipation		Varicose Veins
	Ruptures		Are you pregnant?		Black stool	**EYE, EAR, NOSE, AND THROAT**	
	Broken bones		[ ] Yes [ ] No		Bloody stool		Eye strain
Please mark your areas of pain on the figures below					Hemorrhoids		Eye inflammation
					Liver trouble		Vision problems
					Gall bladder problems		Ear pain
					Weight trouble		Ear noises
				NERVOUS SYSTEM			Ear discharge
					Numbness		Hearing loss
					Loss of feeling		Nose pain
					Paralysis		Nose bleeding
					Dizziness		Nose discharge
					Fainting		Difficult breathing thru nose
					Headaches		Sore gums
					Muscle jerking		Dental problems
					Convulsions		Sore mouth
					Forgetfulness		Sore throat
					Confusion		Hoarseness
					Depression		Difficult speech



Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release my information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of Patient (or parent if a minor) **Date**

1077 Bridgeport Ave, Shelton, CT 06484 Ph: 203-929-5700 Fax: 203-929-5600