Great Basin Chiropractic P.C.
A Creating Wellness Center
Dr. Mark B. Resetarits • Chiropractic Physician

ACCIDENT QUESTIONAIRE

PT ID #_____

Name_____ Date_____

Date of accident_____ Time of accident:_____AM PM

City of accident_____ Address of accident_____

Road conditions at time of accident: WET DRY ICY OTHER_____

Did the police come to the accident scene? YES NO

Were there any traffic citations issued? YES NO To whom?_____

Did paramedics come to the scene? YES NO Were you examined? YES NO

Were you taken to a hospital?_____ If "YES", what is the name of the hospital?_____

How did you get to the hospital?_____. What parts of your body were X-rayed at the hospital?_____MRI Or CT's taken & of what?_____

What treatment was provided or recommendations made (including medications and referrals):
_____

Please list other doctors seen for this accident:_____
_____
_____

THE FOLLOWING QUESTONS PERTAIN TO YOU, THE PATIENT, AND THE VEHICLE YOU WERE IN.

1. Where were you seated in the vehicle? Driver Passenger Back Seat Passenger
2. Were you aware of the impending collision prior to impact, or did the impact take you by surprise? _____
3. Did you lose consciousness/black out upon impact? YES NO, if YES how long do you estimate you were unconscious?_____
4. How far is the top of the headrest or seat back from the top of your head? (approximately.) _____ inches ABOVE or BELOW.
5. Were you wearing a seatbelt?_____; if "YES", was it a lap seatbelt?_____ or shoulder-lap seat belt?_____

Patient Name:_____ Patient ID:_____

6. Is the vehicle equipped with airbags? _____, did they deploy?_____

7. List the year, make and model of the vehicle you were in: YEAR_____, MAKE_____, MODEL_____.

8. What is the damage estimate to the vehicle you were in: $_____ Or Totaled _____

9. Was your car stopped at the time of impact?_____; if "YES", then was the drivers foot also on the brake?_____if "NO", then estimate the speed of the vehicle you were in_____.

10. If the vehicle was moving at the time of impact, was it: (Check one)
    _____ Slowing Down
    _____ Gaining Speed
    _____ Traveling at a steady speed

11. Did your car impact a structure? YES NO. If "YES" was the impact from the
    FRONT LEFT ROLLOVER REAR RIGHT OTHER

12. Please describe, to the best of your knowledge, what happen during this accident:_____
_____.
_____

13. Did you suffer any lacerations as a result of this accident? If yes, where?_____
_____.

14. On what part of the auto did the following body parts hit:
    A. Head hit_____
    B. Chest hit_____
    C. RT. – LT. Shoulder/Arm hit_____
    D. RT. – LT. Hip/Knee hit_____
    E. Other_____

15. Which of the following car parts broke during the accident?
    A. Windshield_____ D. Front seat back_____
    B. RT.-LT. Side window_____ E. Other_____
    C. Steering wheel_____ F. Other_____

16. Was the trunk of your body pointed straight forward at the time of collision? Y N, If "NO", which direction was it turned and how much?_____

17. Was your head pointed straight forward? Y N, if "NO", which direction was it turned and how much?_____

Patient Name:_____ Patient ID:_____

THE FOLLOWING QUESTIONS PERTAIN TO THE **OTHER** VEHICLE INVOLVED IN THE ACCIDENT.

1. What was the year, make, and model of the vehicle?

   YEAR_____, MAKE_____, MODEL_____

2. Was the other vehicle moving at the time of collision? _____, if "YES", what was it's approximate speed? _____

3. If the other vehicle was moving at the time of collision, was it slowing down?_____; gathering speed?_____: or traveling at a steady speed?_____

IF YOU HAVE BEEN IN PREVIOUS ACCIDENTS, PLEASE LIST THE YEAR OF EACH

1._____2._____3._____

Where you treated for these accidents? If yes, where? Type of treatment? (M.D., D.C. P.T.)

_____
_____
_____

YOUR INSURANCE INFORMATION:

Your insurance company name:_____

Your insurance company phone number:_____

Claim number for this accident:_____

Adjuster name:_____

ATTORNEY INFORMATION:

Attorney name:_____ Phone #_____

SYMPTOMS / INJURIES

Have you been able to work since this injury? YES NO How many work days have you missed?_____

Prior to the injury were you able to work on an equal basis with others your age? YES NO

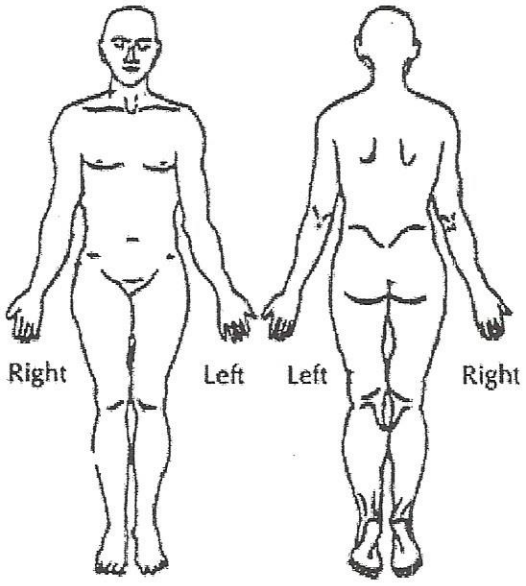
Patient Name:_____ Patient ID:_____

If you have had any of the following symptoms since your injury, please check:

- ❑ Arm/shoulder
- ❑ Low back pain
- ❑ Back stiffness
- ❑ Chest pain
- ❑ Dizziness
- ❑ Ear buzzing
- ❑ Ear ringing
- ❑ Fatigue
- ❑ Feet/toe numbness
- ❑ Hand/finger numbness
- ❑ Headaches
- ❑ Irritability
- ❑ Jaw problems
- ❑ Leg pain
- ❑ Memory loss
- ❑ Nausea
- ❑ Neck pain
- ❑ Mid back pain
- ❑ Shortness of breath
- ❑ Sleep difficulty
- ❑ Stomach upset
- ❑ Tension
- ❑ Blurred Vision

Is this condition getting progressively worse? YES NO UNCLEAR

Mark an X on the picture of the figure where you continue to have pain, numbness, or tingling.



Do your injuries interfere with your: WORK SLEEP DAILY ROUTINE RECREATION

Activities or movements that are painful to perform: (circle all that apply)

SITTING STANDING WALKING BENDING LYING DOWN GETTING UP FROM SITTING

I certify that the above information is correct to the best of my knowledge.

Patient Signature:_____ Date:_____

Witness _____ Date:_____