

West Cobb Chiropractic

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name

DOB

HR#:

Please answer all questions completely

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

Thank you.

Please explain in detail how your accident happened. _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Head Seems too Heavy	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Neck Stiff
<input type="checkbox"/> Pins and Needles in Arms	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Pins and Needles in Legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Irritability
<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Stomach Upset		

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? Yes/ No If yes, admitted? _____ How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes/ No

