

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____ Today's Date: _____

Date of Accident: _____

Describe your Accident:

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN :

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver
 Passenger ----- Location----- Left Middle Right
 Other _____ Front Passenger Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx ____ MPH
 Moving Slowly

Why Vehicle was slowed or stopped:

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection

Collision Type:

- Driver Side Impact Head On Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- Totally unaware that the accident was impending
 Aware that the accident was impending
 Aware that the accident was impending and braced for it

Restraints: (check all that apply):

- Seat belt
 Shoulder harness
 No restraints

If you were the driver of the vehicle, was your foot on the brake pedal?

- Yes No Knocked off by impact

Was the air bag deployed?

- Car not equipped with air bag
 Air bag deployed
 Air bag not deployed

What position was YOUR headrest in?

- High position
 Middle position
 Low position

Position of YOUR head at time of impact?

- Facing straight ahead
 Tilted forward
 Rotated to the left
 Rotated to the right

Was your head thrown...?

- Backward and then forward
 Forward then backward
 To the left To the left, then the right
 To the right To the right, then the left

Position of Your body at time of impact?

- Straight
 Tilted forward
 Rotated to the left
 Rotated to the right

Was your body thrown...?

- Backward and then forward
 Forward then backward
 To the left To the left then the right
 To the right To the right, then the left
 Across the vehicle
 Outside the vehicle Under the vehicle

Damage to vehicle YOU were in:

- Incurred minimal damage \$ _____
 Incurred moderate damage \$ _____
 Incurred severe damage \$ _____
 Was totalled
 Not known

Citations:

- None issued
 Yourself
 Driver of vehicle patient was a passenger of
 Driver of other vehicle
 Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Torso

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door

- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

Next day discomfort...?

- increased
- decreased
- same

Did your major complaints exist before the accident?

- Yes
- No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|----------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |

Low Back Pelvis

In what areas did you experience lacerations (cuts)?

<input type="checkbox"/> Head	Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right

Low Back Pelvis

At the hospital, what areas were x-rayed?

<input type="checkbox"/> Head	Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right

Low Back Pelvis

Where did you experience pain on the day FOLLOWING the accident?

<input type="checkbox"/> Head	Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Thigh	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Upper back	Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Mid back	Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Calf	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ribs	Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Ankle	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	Fingers	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Foot	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	Buttock	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Toes	<input type="checkbox"/> Left	<input type="checkbox"/> Right

Low Back Pelvis

Patient's Signature: _____

DUTIES UNDER DURESS/LOSS OF ENJOYMENT QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Accident: _____

Duties Under Duress

Complete the following summary as it relates to your work duties and your living duties and how the accident injury is still affecting your overall performance at work and home. Check which activity is still affected by the accident injury which requires you to still reduce the time you are capable of performing these activities.

WORK

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Lifting is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Bending is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Sitting at desk is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Repetitive motion is affected	Since MVA Ongoing
<input type="checkbox"/> Walking is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

SCHOOL/STUDY

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Difficulty sitting due to injury	Since MVA Ongoing
<input type="checkbox"/> Difficulty studying due to injury	Since MVA Ongoing
<input type="checkbox"/> Computer work is difficult due to injury	Since MVA Ongoing
<input type="checkbox"/> Difficulty concentrating due to pain	Since MVA Ongoing
<input type="checkbox"/> Walking to classes is affected by injury	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

DOMESTIC DUTIES

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Vacuuming is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Taking care of children	Since MVA Ongoing
<input type="checkbox"/> Cleaning home is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Preparing meals is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

HOUSEHOLD DUTIES

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Yard work is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Driving is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Shopping is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Taking out trash is affected due to injury	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

Loss of Enjoyment

Complete the following summary as it relates to your lifestyle, work environment and activities which you would normally be enjoying, but are currently not enjoying as a result of the accident injury. Check which activity is still affected by the accident injury which requires you to reduce the time you are capable of performing these activities.

WORK

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Lifting is affected by increased pain	Since MVA Ongoing
<input type="checkbox"/> Bending is affected by increased pain	Since MVA Ongoing
<input type="checkbox"/> Sitting at desk causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Completing tasks are affected due to pain	Since MVA Ongoing
<input type="checkbox"/> Walking is affected to to increased pain	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

SCHOOL/STUDY

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Diffifulty sitting due to increased pain	Since MVA Ongoing
<input type="checkbox"/> Difficulty studying due to increased pain	Since MVA Ongoing
<input type="checkbox"/> Computer work is difficult due to pain	Since MVA Ongoing
<input type="checkbox"/> Difficulty concentrating due to pain	Since MVA Ongoing
<input type="checkbox"/> Walking to class increases pain	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

DOMESTIC

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Vacuuming causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Childcare causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Cleaning home causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Preparing meals causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

HOSUEHOLD DUTIES

REASON FOR DIFFICULTY	DURATION
<input type="checkbox"/> Yard work causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Driving causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Shopping causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Taking out trash causes increased pain	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing
<input type="checkbox"/> Other _____	Since MVA Ongoing

Patient's signature: _____

OLD MILL CHIROPRACTIC

DANIEL L. COOGAN, D.C.
235 JUNGERMANN RD. SUITE 209
ST. PETER, MO 63376
PHONE: (636) 928-7387
FAX: (636) 928-1269
www.spinedude.com

Please list all medical visits (i.e. doctors, physical therapists, hospitals, Emergency Room, primary care physicians, etc.) related to this motor vehicle accident.

	PHYSICIAN/HOSPITAL NAME	ADDRESS	PHONE & FAX
1	_____	_____	_____
	_____	_____	_____
2	_____	_____	_____
	_____	_____	_____
3	_____	_____	_____
	_____	_____	_____
4	_____	_____	_____
	_____	_____	_____
5	_____	_____	_____
	_____	_____	_____

_____ I have not had any medical visits related to this motor vehicle accident.

(patient signature)

(date)

OLD MILL CHIROPRACTIC

Daniel L. Coogan, D.C.

235 Jungermann Road, Suite 209

St. Peters, Missouri 63376

(636) 928-7387 Phone

(636) 928-1269 Fax

www.spinedude.com

AUTHORIZATION FOR RELEASE OF RECORDS

Date: _____

I hereby authorize the release of my _____ or copies of such
and request that they be transferred to:

Daniel L. Coogan, D.C.
235 Jungermann Rd., Suite 209
St. Peters, MO 63376
Phone: (636) 928-7387
Fax: (636) 928-1269

Print Name of Patient

Date of Records

Patient Signature

Patient Date of Birth

ATTENDING DOCTOR

Doctor's Name

Address

City/State/Zip

Phone

Fax