Old Mill Chiropractic
235 Jungermann Rd., Suite 209, St. Peters, MO 63376
Phone: (636) 928-7387 Fax: (636) 928-1269

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name: _____

Today's Date: _____ Date of Accident: _____

Please give a written description of 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 approx ____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 totaled
❑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 ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Left Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Right Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Torso

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Left Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Right Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑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 ❑Weak
❑Dazed ❑Nervous
❑Disoriented ❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

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

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left ❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left ❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left ❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left ❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left ❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left ❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left ❑Right
❑Low Back ❑Pelvis					

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left ❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left ❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left ❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left ❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left ❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left ❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left ❑Right
❑Low Back ❑Pelvis					

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

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left ❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left ❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left ❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left ❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left ❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left ❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left ❑Right
❑ Low Back ❑Pelvis					

Patient Signature: _____ **Date:** _____

Activities of Daily Living/Duties Under Duress

Patient Name: _____Date: _____

Activities that are affected by my current health condition

n/a = Not applicable
0 = No affect
1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problem (Moderate)
3 = I can't do this activity at all (Severe)

Basic

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting
_____ Standing
_____ Staying Asleep
_____ Walking

Daily Living

_____ Caring for Sick or Elderly Family Member
_____ Child Care
_____ Computer Use (extended time)
_____ Computer Use (short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading

Daily Living (continued)

_____ Sexual Activity
_____ Yard Work

Occupational Duties

_____ Computer
_____ Desk Work
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone

Personal Care

_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving

Recreational Activities

_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Piano
_____ Running
_____ Sewing
_____ Softball
_____ Swimming
_____ Tennis

Please list all medical visits related to your motor vehicle accident. (i.e. any type of doctor, physical therapist, hospital emergency room, urgent care clinic,etc.)

Physician/Facility Name: _____
Address: _____
Phone: _____Fax: _____

Physician/Facility Name: _____
Address: _____
Phone: _____Fax: _____

Physician/Facility Name: _____
Address: _____
Phone: _____Fax: _____

Physician/Facility Name: _____
Address: _____
Phone: _____Fax: _____

Physician/Facility Name: _____
Address: _____
Phone: _____Fax: _____

☐ I have not had any medical visits related to my motor vehicle accident.

Patient Name: _____

Patient Signature: _____Date: _____

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St. Peters, MO 63376
Phone: (636) 928-7387
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www.spinedude.com

Authorization for Release of Records

Today's Date: _____

Name of Patient: _____Date of Birth: _____

I certify that I am the patient named above and I am requesting a limited, one-time authorization to release my records to Old Mill Chiropractic for the purpose of chiropractic evaluation/treatment. I understand that authorizing the disclosure of this health form is voluntary. I understand that I may inspect the information to be used or disclosed.

Patient Signature: _____Date of Records: _____

I hereby authorize:

Doctor/Facility Name: _____

Address: _____

Phone: _____

Fax: _____

To release my: _____ X-Rays _____ Radiology/MRI/CT Scan Reports _____ Medical Records

_____ Other: _____

or copies of such and request that they be faxed or mailed to:

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

OLD MILL CHIROPRACTIC, LLC
DANIEL L. COOGAN, D.C.
235 JUNGERMANN ROAD, SUITE 209
ST. PETERS, MO 63376
PHONE: 636-928-7387
FAX: 636-928-1269
EMAIL: info@spinedude.com

PATIENT NAME: _____

Your Automobile Personal Injury (Medical Payments) Insurance Claim Information

INSURANCE COMPANY NAME: _____

CLAIM NUMBER #: _____

INSURANCE CO. PHONE #: _____

INSURANCE CO. FAX #: _____

INSURANCE CO. ADDRESS: _____

_____

CONTACT PERSON/ADJUSTER: _____

MED PAY POLICY LIMIT: _____

Liability Insurance Injury Claim Information

NAME OF PERSON AT FAULT: _____

ADDRESS OF PERSON AT FAULT: _____

_____

INSURANCE COMPANY: _____

CLAIM NUMBER #: _____

INSURANCE CO. PHONE #: _____

INSURANCE CO. FAX #: _____

INSURANCE CO. ADDRESS: _____

_____

CONTACT PERSON/ADJUSTER: _____