

Accident/Injury Questionnaire
M^cCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

Patient: _____ **#:** _____

Today's Date: ____/____/____

A. DATE AND TIME OF ACCIDENT/INJURY

Date: ____/____/____ Time: ____:____ am/pm

B. DESCRIPTION OF ACCIDENT/INJURY

Automobile Crash Workmen's Compensation

Other: Accident Injury _____

C. DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED

D. DETAILS OF AUTOMOBILE ACCIDENT

1. Your Vehicle

a) **Type:** _____

b) **Vehicle Size**

Compact Mid-Size Full-Size Other: _____

c) **What Was Your Location In The Vehicle?**

Driver Front Passenger **Rear:** Left Middle Right

d) **What Damage Did The Vehicle You Were In Sustain?**

Minimal Moderate Extensive Totaled Unsure

2. Other Vehicle

a) **Type:** _____

b) **Vehicle Size**

Compact Mid-Size Full-Size Other: _____

c) **How Did This Vehicle Strike The Vehicle You Were In?**

Heads On From Right From Left Rear Ended

Sideswiped On Left Sideswiped On Right Other: _____

d) **What Damage Did The Other Vehicle Sustain?**

Minimal Moderate Extensive Totaled Unsure

3. Describe Any Other Vehicle(s) To Strike The Vehicle You Were In

4. Were Traffic Citations Issued As A Result Of The Accident?

No Driver Of Your Vehicle Driver Of Other Vehicle You Unsure

Accident/Injury Questionnaire
M^cCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

5. Conditions At The Time Of Accident?

- a) **Timing:** Daylight Night Dawn Dusk Other: _____
b) **Road:** Dry Wet Snow Covered Icy Other: _____
c) **Visibility:** Good Fair Poor Other: _____

6. At Moment Of Impact

- a) **Were You Prepared For The Accident?**
No Yes
b) **Were You Wearing A Seatbelt?**
No Yes If Yes: Shoulder Belt Shoulder-Lap Belt Lap Belt
c) **Was The Vehicle Equipped With Headrests?**
No Yes If Yes, Location: Low Middle High Unknown
d) **Did Airbags Deploy?**
No Yes

7. Your Body Positioning

- a) **What Was Your Body Position At Impact?**
Straight Slouched Forward **Rotated:** Left Right
Don't Recall Other: _____
b) **What Direction Was Your Body Thrown?**
Forward/Backwards Sideways Across Vehicle
Outside Vehicle Don't Recall Other: _____

8. Your Head/Neck Positioning

- a) **What Was Your Head/Neck Position At Impact?**
Straight Tilted Forward **Rotated:** Left Right
Don't Recall Other: _____
b) **Through What Motion Were Your Head/Neck Thrown?**
Forward/Backwards Sideways Don't Recall
Other: _____

9. Result Of Impact

- a) **Did The Force Of Impact Cause Your Head/Neck To Strike Anything?**
No Yes If Yes, Then What: _____
b) **Did The Force Of Impact Cause Any Other Part OF Your Body To Strike Anything?**
No Yes If Yes, Then What: _____

E. IMMEDIATELY AFTER THE ACCIDENT

1. Did You Lose Consciousness?

- Yes No Don't Know

2. How Did You Feel?

- Confused Dazed Dizzy Nervous Weak Other: _____

3. Where Did You Immediately Feel Pain?

- Head Neck Upper Back Mid Back Low Back Arms Legs
Other: _____

Accident/Injury Questionnaire
M^cCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

4. Did You Receive Emergency Care?

No Yes If Yes, Then Describe Care: _____

5. Destination After Accident/Injury

Hospital Home Work School Other: _____

F. HOSPITAL VISIT AFTER THE ACCIDENT/INJURY

1. When Did You Go?

Immediately Later That Day Next Day Days Later

Other: _____

2. Were X-rays Taken?

Yes No

3. Was A CAT Scan Performed?

Yes No

4. Was An MRI Performed?

Yes No

5. What Was The Diagnosis(es) Given At The Hospital?

6. What Treatment(s) Was/Were Given At The Hospital?

7. What Recommendations Were Made?

G. FOLLOWING THE ACCIDENT/INJURY

1. What, If Any, Additional Symptoms Developed?

2. How Much Later Did Additional Symptoms Develop?

Immediately Hours That Evening Next Morning Days Week

Month Other: _____

Accident/Injury Questionnaire
M^cCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

3. Since Your Accident/Injury Have You Suffered From?

- Blurred Vision Double Vision Reduced Vision Impaired Hearing
 Ringing In Ears Chest Pain Difficulty Breathing Palpitations
 Constipation Diarrhea Nausea Vomiting Frequent Urination
 Inability To Hold Urine Painful Urination Anxiety Depression
 Mood Swings Nervousness Poor Memory Tension Convulsions
 Dizziness Headaches Fainting Loss Of Balance Fatigue
 Restlessness Insomnia Light Sensitivity Reduced Appetite
 Weakness Weight Gain Weight Loss Other: _____

4. Has The Accident/Injury Restricted Your Activities?

- No Yes If Yes, Describe: _____

5. Have You Missed Work Due To This Accident/Injury?

- Missed No Work Limited Work Activity
 Missed Work From: ____/____/____ to ____/____/____

6. Did You Self Treat Your Symptoms?

- No Yes If Yes, Then How Or With What: _____

H. INSURANCE/ATTORNEY INFORMATION

1. Have You Contacted An Insurance Adjuster Or Representative Regarding This Claim?

- No Yes If Yes, Company: _____
Adjuster: _____ Claim #: _____

2. Have You Engaged Services Of An Attorney?

- No Yes If Yes, Attorney: _____
Address: _____
City: _____ State: ____ ZIP: _____
Phone: (____) ____ - _____

3. Have You Filed An Accident/Injury Report?

- No Yes

4. Have You Filed For Insurance Benefits?

- No Yes

Patient Or Guardian's Signature

____/____/____
Date