DuPage Healthcare, Ltd

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.

PATIENT DEMOGRAPHICS **Today's Date: _____**

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____@ _____

Home Phone: _____Mobile Phone: _____ Work Phone: _____

Marital Status: ❑ Single ❑ Married Do you have Health Insurance: ❑ Yes ❑ No

Primary Insurance: _____ Name of Person Who Carries Primary: _____DOB: _____

Secondary Insurance: _____ Name of Person Who Carries Secondary: _____DOB: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____
Spouse's Name _____Spouse's Employer _____
Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Fill in the below if your injuries are the result of a motor vehicle accident:

Date of injury: _____

Driver of other vehicle:
Name_____Insurance Company_____ Policy No. _____

Driver of vehicle in which you were injured in:
Name_____ Insurance Company_____Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ❑ Yes ❑ No
If so, his/her name and address_____ Phone: _____

Fill in the below if your injuries are the result of an accident at work:

Date of Injury: _____
Accident reported to employer? ❑ Yes ❑ No

Name of supervisor accident was reported to: _____ Phone: _____

Patient's Name _____ **DOB** _____ **HR#:** _____

Please fill in the below information that is relevant to your work, automobile accident, or other. If it doesn not relate to your situation mark N/A.

Please explain in detail how your accident happened. _____
_____
_____
_____

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:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____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

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given?_____

How often did you see the doctor? _____

How long did you see the doctor? _____

Patient's Name **DOB** **HR#:**

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since this injury are your symptoms, improving? Getting worse? Same?

You were heading North/ East/ South/ West on _____(street or highway)

Other vehicle was heading North/ East/ South/ West on _____(street or highway)

Were police notified? ❑ Yes ❑ No

Were you knocked unconscious? Yes/ No If so, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side_____

You were Driver/ Passenger/ Front seat/ Back Seat/ using seat belts_____

Patient's Name DOB HR#:

Patient signature DATE

Doctor signature DATE