Bonsall Chiropractic Motor Vehicle Accident Questionnaire

Patient #: ____________

13. What are your PRESENT complaints and symptoms?: ____________

14. Do you have any congenital (from birth) factors which relate to this problem?: ☐ Yes ☐ No If yes, please describe: ____________

15. Do you have any previous illnesses which relate to this case?: ☐ Yes ☐ No If yes, please describe: ____________

16. Have you ever been involved in an accident before?: ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: ____________

17. Where were you taken after the accident?: ____________

18. Have you been treated by another doctor since the accident?: ☐ Yes ☐ No If yes, please list doctor's name and address: ____________

    What type of treatment did you receive?: ____________

19. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

20. CHECK SYMPTOMS YOU HAVE NOTICED **SINCE** THE ACCIDENT:

O Headache	O Irritability	O Numbness in Toes	O Face Flushed	O Feet Cold
O Neck Pain	O Chest Pain	O Shortness of Breath	O Buzzing in Ears	O Hands Cold
O Neck Stiff	O Dizziness	O Fatigue	O Loss of Balance	O Stomach Upset
O Sleeping Problems	O Head Seems too Heavy	O Depression	O Fainting	O Constipation
O Back Pain	O Pins & Needles in Arms	O Lights Bother Eyes	O Loss of Smell	O Cold Sweats
O Nervousness	O Pins & Needles in Legs	O Loss of Memory	O Loss of Taste	O Fever
O Tension	O Numbness in Fingers	O Ears Ring	O Diarrhea	O ____________

    Symptoms Other than Above?: ____________

21. Have you lost time from work as a result of this accident?: ☐ Yes ☐ No If yes, please complete this question.
    a. Last Day Worked: ____________
    b. Type of Employment: ____________
    c. Present Salary: ____________
    d. Are you being compensated for time lost from work?: ☐ Yes ☐ No If yes, please state type of compensation you are receiving: ____________

22. Do you notice any activity restrictions as a result of this injury?: ____________

23. Other pertinent information: ____________

____________ Date

____________ Patient's Signature