# Lundstrom Chiropractic
# Automobile Accident Questionnaire

## Patient Information

Patient Name:_____

Mailing Address:_____

Home Phone:_____ Mobile Phone:_____

Email Address:_____

Date of Birth:_____ Male ☐ Female ☐

Employer:_____ Occupation:_____

Marital Status:_____ Spouse Name:_____ Spouse Date of Birth:_____

Emergency Contact:_____ Phone Number:_____

How were you referred to our office?:_____

## Account Information

Name of your Auto Insurance:_____

Name of Insurance Adjuster, if applicable:_____

Phone Number:_____ Fax Number:_____

Claim Number:_____

Have you completed your PIP application? YES ☐ NO ☐

Have you retained an Attorney? YES ☐ NO ☐

If so, Name of Attorney or Paralegal:_____ Phone Number:_____

## Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with the above stated insurance companies and assign directly to Lundstrom Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether of not paid my insurance. I authorize the use of my signature on all insurance submissions.

Lundstrom Chiropractic may use my health care information and may disclose such information to the above insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature:_____

Date:_____

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## Accident Information

Please describe the details of your accident:_____

_____

_____

_____

You were the DRIVER ☐ PASSENGER ☐ Heading NORTH ☐ SOUTH ☐ EAST ☐ WEST ☐ on _____

OTHER Driver was headed NORTH ☐ SOUTH ☐ EAST ☐ WEST ☐ on _____

You were struck from BEHIND ☐ FRONT ☐ DRIVER'S SIDE ☐ PASSENGER'S SIDE ☐ Were you wearing a Seat Belt? YES ☐ NO ☐

Date & Time of the Accident?_____

Where did you feel pain immediately after the accident?_____

Where were you taken after the accident?_____ Was treatment given? YES ☐ NO ☐

Have you consulted with any other doctor's regarding this injury? YES ☐ NO ☐ If so, Doctor's Name:_____

## Patient Condition

Reason for visit (neck pain, low back pain, etc.) _____

Please rate the severity of your pain on a scale of 1 (very minimal) to 10 (severe/debilitating):_____

How are your symptoms progressing? Getting Better ☐ Getting Worse ☐ About the Same ☐

Please describe your symptoms:

| | | | | | |
|---|---|---|---|---|---|
| Sharp | ☐ | Dull | ☐ | Stabbing | ☐ |
| Tingling | ☐ | Weakness | ☐ | Tenderness | ☐ |
| Stiffness | ☐ | Swelling | ☐ | Burning | ☐ |

Are your symptoms CONSTANT, ☐ or do they COME & GO? ☐

Do your symptoms **INTERFERE** with any of the following activities?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Sitting | ☐ | Driving | ☐ | Lift/Carrying | ☐ | Sleeping | ☐ | Walking | ☐ |
| Chores | ☐ | Dressing | ☐ | Standing | ☐ | Self Care | ☐ | Exercise/Recreation | ☐ |

Are your symptoms made **WORSE** by any of the following activities?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Twisting/Turning | ☐ | Bending Forward | ☐ | Walking | ☐ | Sitting | ☐ |
| Cough/Sneeze | ☐ | Bending Backward | ☐ | Lying Down | ☐ | Standing | ☐ |

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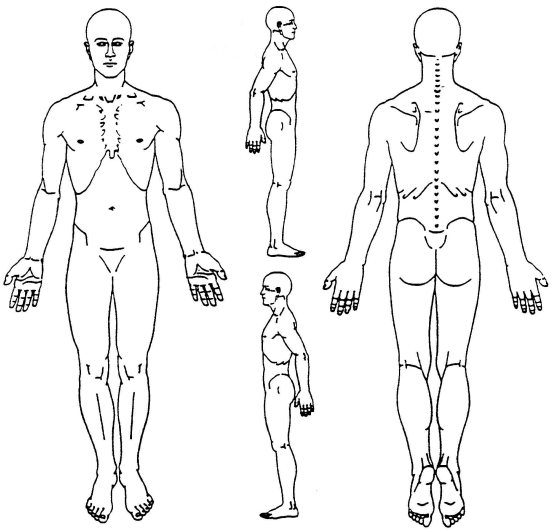
**Please use the drawing to label the areas of your symptoms**



Please date any significant injuries/surgeries that you have had:

Falls_____ Head injuries_____ Broken bones_____

Dislocations_____ Surgeries_____ Other _____

How often do you exercise?_____

Describe your work activity:_____

Do you smoke? NO YES How much?_____

Do you drink alcohol? NO YES How much?_____

Do you drink caffeine? NO YES How much?_____

How many hours of sleep do you get? _____

## Family History

Please mark the following conditions that pertain to your immediate family

| | Father | Mother | Brother | Sister |
|---|---|---|---|---|
| Arthritis | ☐ | ☐ | ☐ | ☐ |
| Back Pain | ☐ | ☐ | ☐ | ☐ |
| Blood Disorders | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Heart Problems | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ |

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**Past History**

Please mark the following conditions that you have ever suffered from.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cancer | ☐ | Gout | ☐ | Kidney Disease | ☐ | Prostate problem | ☐ |
| Diabetes | ☐ | Heart Disease | ☐ | Liver Disease | ☐ | Stroke | ☐ |
| Emphysema | ☐ | Hernia | ☐ | Mental Disorders | ☐ | Thyroid problem | ☐ |
| Epilepsy | ☐ | Herniated Disc | ☐ | Pinched Nerve | ☐ | Ulcers | ☐ |

**I understand and agree to the following:**

- **I have completed this form accurately and to the best of my knowledge.**
- **A history, consultation, examination and x-rays are conducted for diagnostic / informational purposes, and I am requesting these services, as well as consenting to treatment and possible risks associated with treatment performed within this office.**
- **It is my responsibility to notify the doctor if any of my information has changed or requires updating.**

**Patient**

**Signature:**_____ **Date:**_____