IMPASTATO CHIROPRACTIC
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METAIRIE, LA 70002
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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

Name:____________________________________ Date of Accident:________________Time:__________

Driver of vehicle in which you were injured:____

Insurance Company:____ Policy #:________________

Claim #:______________________________ Phone #:____________________

Driver of other vehicle:____ Policy #:__________________

Insurance Company:____ Claim #:___________________

Adjuster:____ Phone#:____________________________

Have you retained an attorney?___Yes___No Attorney's Name: _______________________________

Address:____Phone#:________________

Describe the accident in detail:____

Were police notified? ___Yes ___No

What was your position in the car? ___driver ___passenger

If passenger, were you sitting in the car? ___front___right rear ___left rear

What type of vehicle were you in?________________________________

You were heading? ___North ___East ___South ___West on _____________________(street or highway)

Other vehicle was headed? ___North ___East ___South ___West on _______________(street or highway)

Was the impact from the: ___front ___right side ___left side ___rear

Was the vehicle in: ___park ___neutral ___in gear ___moving ___stopped

Were brakes being applied? ____ Was vehicle being shoved? ___forward ___backwards ___sideways

Were you shoved forward and whipped backwards at a rapid force, while hitting your head? ______

Did your head override headrest and springboard forward? ________

Did your hat or glasses end up in the back seat or under the rear window? ____Yes___No

Did any other part of your body hit any part of the interior?____ Console?_____ Steering wheel?_____

Dashboard?____ Windshield?_____ Arm rest?_____ Side door window?____ Part of body?____

Parts of body: _____Chest _____Chin _____Knee _____Shoulder _____Hand _____Head

Were you wearing your seat belts? ____ Yes ____ No Did they break upon impact? ____Yes ____ No

Was the impact? ___expected___unexpected If expected, did you brace for the impact? ____Yes ___No

If Yes, what did you brace against? _______ Did your seat belt have a shoulder harness? ____Yes ___ No

Did it contribute to the pain? ___ Yes ___No Which way was your head turned? ________________

The headrest was? ___ up ___ down? How far was your head from the head rest at point of accident?

____

Did the seat cushion your impact or spring you forward?____

At the point of impact, where did you experience the pain sensation(s)?____________________________

Were you knocked unconscious? ___Yes ___No In a daze? ___Yes ___No

Where did you feel pain immediately after the accident?____

Did you go to the hospital? ___Yes ___No If yes, when? ____At time of accident ____Next day

How did you get to the hospital?____Ambulance _____Own transportation

Name of hospital ____ Attended by Dr.______________________

Were you x-rayed at the hospital? ___Yes ___No If so, what was the diagnosis?______________________

Were you admitted to the hospital? ___Yes ___No How long did you stay?__________________________

Was any other doctor consulted after your accident? ___Yes ___No

If yes, Dr's Name: ______________________________ Diagnosis:________________________________

What treatment was given?____

How often did you see the doctor? ___________________ How long did you see the doctor?____________

Have you ever had any complaints in the involved area before? ___Yes ___No

If so, give details: ____

Is your pain constant?___Yes___No Is the pain on and off?___Yes___No Sharp?___Yes___No

Dull?___ Yes___ No

Did you have numbness or tingling in your arms?___Yes___No In your hands?___Yes___No

In your fingers? ____Yes ____No In your legs? ____Yes ____No In your feet? ____Yes ____No

Do your knees ache? ____Yes ____No Do you have cramps in your legs? ____Yes ____No

In your arms?___Yes___No

Do any of the following relieve your pain?___ Heating pad ____ Hot bath ____Shower ___Ice pack

___Rest ___Medication

What type of work do you do?____

Have you lost time at work because of the accident?___Yes ___No

If yes, give dates of time lost: from ______________________ to ________________________________

Are you required to lift over 10lbs?___Yes ___No

Before the injury were you capable of working on an equal basis with others your age?___Yes ___No

Totally disabled from _______________________ to _______________________.

Partially disabled from _______________________ to _______________________.