SMALL MIRACLES
NATURAL HEALTH CENTER
Chiropractic-Nutrition-Massage

# Motor Vehicle Accident Questionnaire

Name: _____ Date of Birth: _____ Today's date: _____
Date of injury:_____ Were you the: driver / front passenger / rear passenger Wearing seatbelt? Y / N
Were the police notified? Y / N Do you have an accident report? Y / N Were you knocked unconscious? Y / N
Have you retained an attorney? Y / N / not yet but plan to Attorney's name:_____
Attorney located:_____
Was this reported to your auto insurance? Y / N Do you have MedPay on your auto insurance policy? Y / N
Please explain how the accident happened: _____
_____
_____
Did you feel pain immediately after the accident? Where? _____
_____
Did an ambulance come to the scene? Y / N Did an ambulance bring you to the hospital? Y / N _____
Were you seen in the emergency room for this condition(s)? Y / N – Date: _____
Name of hospital: _____
Did you consult any other doctor(s) after your accident? :_____
List any treatment you have received since the accident: _____
Check off any of the below studies that were completed for this condition(s) & where they were taken:

☐ X-ray - Area of study: _____ Facility name & location: _____
☐ MRI - Area of study: _____ Facility name & location: _____
☐ CT scan - Area of study: _____ Facility name & location: _____

Please check off any symptoms you have noticed **since the accident**:

| | | | |
|---|---|---|---|
| __ Fatigue | __ Sensitivity to light | __ Difficulty sleeping | __ Cold feet |
| __ Fainting | __ Neck pain | __ Facial flushing | __ Muscle spasms |
| __ Dizziness | __ Neck stiffness | __ Stomach upset | __ Back pain |
| __ Weakness | __ Anxiety | __ Constipation | __ Chest pain |
| __ Loss of memory | __ Depression | __ Diarrhea | __ Ringing in ears |
| __ Numbness/tingling | __ Poor concentration | __ Shortness of breath | __ Nose bleeds |
| __ Fever | __ Nervousness | __ Loss of smell | __ Jaw pain/clenching/clicking |
| __ Vomiting | __ Irritability | __ Loss of taste | __ Head heaviness |
| __ Nausea | __ Brain fog | __ Loss of balance | __ Cold sweats |
| __ Headache | __ Mood swings | __ Cold hands | __ Pins & needles |

Other symptoms: _____
_____

## Motor Vehicle Accident Terms of Agreement

I understand and agree that my health and auto insurance policies are an arrangement between my insurance carrier/s and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in filing my insurance claims, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account. However, I understand that ultimately I am personally responsible for payment for all services rendered to me.

Patient/Guardian Signature: _____ Date: _____