TEXSTAR CHIROPRACTIC
4601 SOUTHWEST PARKWAY #101, AUSTIN, TX 78735
PHONE: (512) 899-2228 FAX: (512) 899-2226 CLINIC DIRECTOR: MICHAEL P. HENRY D.C.

Auto Accident Questionnaire Form

Patient Name: _____ File No.: _____

Date of Accident:_____ Time of Accident:_____

During the Motor Vehicle Accident…

1. Were you the [ ]driver [ ]front seat passenger [ ]left or [ ]right rear seat passenger? Other_____
2. Was your vehicle stopped? [ ]Yes [ ]No. If not, how fast was it going? _____MPH
3. Make, model, year of your vehicle_____
4. What was your vehicle doing immediately prior to impact (i.e. changing lanes, driving through an intersection)?_____
5. Were you struck from [ ]behind, [ ]head on collision (front), [ ]broadside [ ]right [ ]left, [ ]multi-car collision, [ ]no collision. Other_____
6. What was the estimated damage to your vehicle?_____
7. The road condition was [ ]dry [ ]damp [ ]wet.
8. The accident occurred during [ ]dawn [ ]daylight [ ]dusk [ ]night.
9. Was another vehicle involved? [ ]Yes [ ]No. Number of other vehicles _____ Which vehicle hit the other? _____
10. Were the police notified? [ ]Yes [ ]No. Was a report made? [ ]Yes [ ]No
11. Did the airbags deploy? [ ]Yes [ ]No
12. Was your seat equipped with a stationary, adjustable headrest? [ ]Yes [ ]No.
13. Were you using seatbelts? [ ]Yes [ ]No. Were you using a shoulder harness? [ ]Yes [ ]No.
14. Did you anticipate the accident? [ ]Yes [ ]No.
15. Was your foot on the brake at the time of impact? [ ]Yes [ ]No. Was your foot knocked off the brake at the time of impact? [ ]Yes [ ]No.

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16. What direction was your head facing during the accident? [ ]straight forward [ ]right [ ]left Other_____
17. Were you knocked unconscious? [ ]Yes [ ]No. If yes, for how long?_____
18. Were you treated by paramedics? [ ]Yes [ ]No_____
19. Where did you go after the accident? (home, hospital, etc.)_____
20. Make, model, year of car(s) that struck you._____
21. How fast was the other vehicle traveling? _____MPH
22. What was the other vehicle doing immediately prior to impact (i.e. changing lanes, driving through an intersection)?_____
23. What was the other vehicles point of impact (i.e. front bumper, passenger's side, etc.). _____

Please check symptoms that you are presently experiencing that have occurred since the accident:

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

Symptoms other than above _____

Other pertinent information _____

_____

_____

_____ _____

Signature (Patient or Guardian) *Date*