Jones Chiropractic Clinic
Drs. Jones and Leu
801 E. Watauga Ave, JC, TN 37601
423-929-8700
423-929-8780 fax
www.joneschiroclinic.com

AUTO ACCIDENT HISTORY AND QUESTIONNAIRE

Please print clearly.

Today's Date (Mm/Dd/Yyyy)

Name (Last, First, Middle Initial) Gender ○ Male ○ Female Social Security Number

Birth Date (Mm/Dd/Yy) Age Date And Time Of The Accident Where Was The Accident? (City/State)

Describe In Your Own Words How The Accident Occurred

(Cont.)

Was A Police Report Filed? ○ Yes ○ No How Many Vehicles Were Involved In The Accident? Your Vehicle Model And Make Other Vehicle(s) Model And Make

What Direction Were You Traveling And On Which Street? What Direction Was The Other Vehicle Traveling And On Which Street?

Did You Anticipate The Impact Or Were You Caught By Surprise? Did You Have A Seat Belt On? ○ Yes ○ No W/Shoulder Harness? ○ Yes ○ No

Did You Brace Your Arms/Hands Against Any Part Of The Vehicle? ○ Yes ○ No If Yes, What Part?

Did You Brace Your Legs Against The Floorboard? ○ Yes ○ No Was Your Foot On The Break? ○ Yes ○ No

At The Time Of Impact Were You ○ Looking Forward ○ Looking Left ○ Looking Down ○ Looking Right ○ Looking Up

What Was The Position Of Your Torso At The Time Of Impact? ○ Straight Forward ○ Rotated Right ○ Rotated Left

Did Any Other Part Of Your Body Hit The Interior Of The Vehicle? ○ Yes ○ No If Yes, What Or Where?

What Kind Of Headrest Was In Your Seat? ○ Moveable (Hi pos MED pos LOW pos) ○ Non-Moveable ○ None

Did Your Hat/Glasses Fall From Your Head During The Accident? ○ Yes ○ No

What Portion Of Your Car Was Impacted? ○ Rear ○ Font ○ Right side ○ Left side

During And After The Crash, What Happened To Your Vehicle? ○ Kept Going Straight ○ Kept Going Straight Hitting Car In Front ○ Was Hit By Another Car ○ Spun Around ○ Spun Around And Hit A Stationary Object ○ Hit A Stationary Object ○ Other

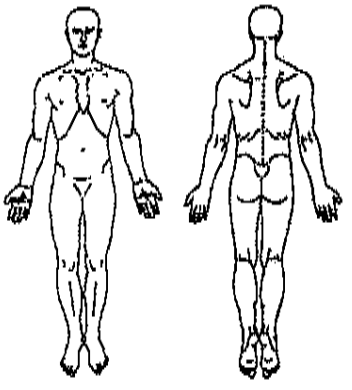
Your Vehicle: ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving ____ MPH

Other Vehicle #1: ○ In Park ○ In Gear ○ Stopped ○ In Neutral ○ Moving ____ MPH

Other Vehicle #2: ○ In Park ○ In Gear ○ Stopped ○ In Neutral ○ Moving ____ MPH

What Are The Estimated Monetary Damages To Your Vehicle? Please Note Any Extraordinary Damage Details

Where Did You Immediate Notice Pain Or Symptoms? (Please Mark With An "X") Since The Accident Are Your Symptoms: ○ Better ○ Worse ○ Same



Where Were You Located In The Vehicle? ○ Driver ○ Front Passenger ○ Rear Passenger Driver Side ○ Rear Passenger Right Side ○ Third Seat Driver Side ○ Third Passenger Side ○ Center Seat

Were You Unconscious? ○ Yes ○ No If Yes, For How Long?

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Brion Jones, DC ____ David Leu, DC ____

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Did You Go To The Hospital/ER After The Accident? ○ Yes ○ No

Name/Location Of Hospital/ER

When?

Did You Go To Hospital By Ambulance? ○ Yes ○ No

If Yes, Did They Use: ○ Neck Brace ○ Back Brace ○ Other:

If No, Where Did You Go?

Did The Ambulance Workers Give You Any Medications Or Supplies? ○ Yes ○ No

If You Were Given Medications Or Supplies, Please List Them

If You Were Hospitalized:

Were You There Overnight? ○ Yes ○ No

What Medications Did You Receive?

Were X Rays Taken? ○ Yes ○ No

If Yes, What Areas?

What Diagnosis Was Given?

What Were The Treating Doctors' Recommendations?

Since The Accident Have You Been To Any Other Doctors? ○ Yes ○ No

If Yes, Name Of Doctor(s) And Location

What Was Their Diagnosis?

Did They Recommend Any Treatment?

What Medications Or Treatments Have You Received?

Have You Ever Had Similar Symptoms In The Past? ○ Yes ○ No

If Yes, Please Explain

Have You Lost Any Days From Work? ○ Yes ○ No

If So, How Many And Dates

What Is Your Occupation?

What Are Your Job Requirements?

Is There Anything Else You'd Like Us To Know? Please Use The Space Below.

Signature

Date

Jones Chiropractic Clinic

Brion Jones, DC ____ , David Leu, DC ____

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