Hulsebus Machesney Park Chiropractic Clinic
1010 Harlem Road
Machesney Park, IL 61115
Phone (815) 654-1044

Auto Accident Questionnaire

Today's Date: ____________________

Name: ____ Date of Birth: ___/___/______ Age: _______

Address: _______________________________ City:____________________ State: ______ Zip: _______

Home Phone #: __________________ Cell #: _________________ Email: ________________________

Social Security #: _________________ Employer: _________________

Marital Status: _____________ Spouse's Name: _______________________ Phone #: ______________

How were you referred to this office? ____

Nature of Accident:

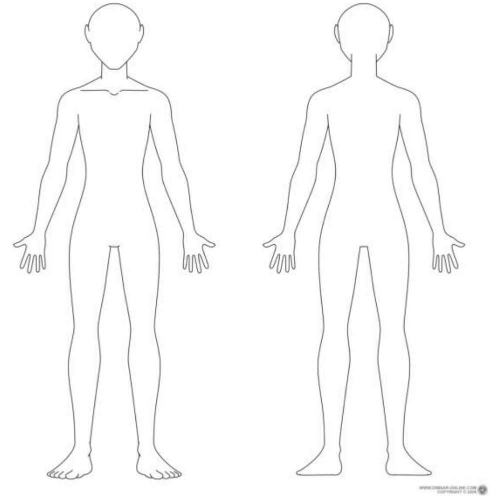
1. Date of accident: _____________ Time of Day:___________ (am/pm)
2. Were you the ( ) Driver or ( ) Passenger?
3. If a passenger were you in the ( ) Front or ( ) Back seat?
4. Number of people in vehicle? ______ Other vehicle? ______
5. In which direction were you headed? ( ) North ( ) South ( ) East ( ) West
   on (name of street) ____
6. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
   on (name of street) ____
7. Were you struck from: ( ) Behind ( ) Front ( ) Right side ( ) Left side
8. Were you wearing a seatbelt? ( ) Yes ( )No
9. Were the police notified? ( ) Yes ( ) No
10. Are you the owner of the car? ( ) Yes ( )No
    If not, who is? ____
11. State how the accident happened in your own words:
    ____
    ____
    ____
    ____
12. Describe in your own words what happened to you upon impact:
    ____
    ____
    ____
13. Please describe how you felt:
    a. DURING the accident: ____
    b. IMMEDATEILY AFTER the accident: ____
    c. THE NEXT DAY: ____
14. What are your present complaints or symptoms:
    ____
    ____

15. Check Symptoms you have noticed since the accident:

___ Headache
___ Neck Pain
___ Neck Stiff
___ Sleeping Problems
___ Depression
___ Lights Bother Eyes
___ Loss of Memory
___ Ears Ring
___Buzzing in Ears
___ Loss of Balance
___ Fainting
___ Loss of Smell
___ Loss of Taste
___ Diarrhea
___ Shortness of Breath
___ Pins & Needles in Arms
___ Numbness in Fingers
___ Other_____________

___ Irritability
___ Chest Pain
___ Dizziness
___ Head Seems too Heavy
___ Back Pain
___ Nervousness
___Tension
___ Face Flushed
___ Hands Cold
___ Stomach Upset
___ Constipation
___ Cold Sweats
___ Fever
___ Numbness in Toes
___ Fatigue
___ Pins & Needles in legs
___ Feet Cold

16. Please mark on figures:



Mark Pain Area

+++ Burning 000 Stabbing
---- Sharp III Constant

17. Did you have similar complaints BEFORE the accident? ( ) Yes ( )No
If yes, please describe in detail:
____
____
18. Where were you taken after the accident? ____
19. Have you been treated by another doctor since the accident? ( ) Yes ( )No
If yes, please list doctor's name and address:
____
____
What type of treatment did you receive? ____
Are you still being treated? ( )Yes ( )No
20. Did you get bleeding cuts or bruises? ( ) Yes ( )No
21. Since the injury, are your symptoms: ( )Improving ( )Getting Worse ( )Same
22. What was the approximate damage done to your car? __________________________________
23. Have you missed any time from work? ( ) Yes ( )No
If yes, the name of your employer: ____
Have you returned to work? ( ) Yes ( ) No
If yes, date you returned: ________________
24. Do you have an attorney for this case? ( ) Yes ( ) No If yes, who?
Name: ____________________________ Address: ____________________________________
City/State/Zip: _____________________
25. Were there any witnesses? ( ) Yes ( ) No
If yes, list name(s): ____

Insurance Information:

Your Insurance Information: Claim #: ___________________
Name: ____________________________ Phone#: ___________________ Policy #: __________________
Address: ___________________________________ City/State/Zip: ______________________________
Adjuster's Name: ____________________________ Phone # ________________ Ext: _________________
Adjuster's Email: ___________________________________

Other Driver's Insurance Information: Claim #: ___________________
Name: ____________________________ Phone#: ___________________ Policy #: __________________
Address: ___________________________________ City/State/Zip: ______________________________
Adjuster's Name: ____________________________ Phone # ________________ Ext: _________________
Adjuster's Email: ___________________________________

Which Insurance Company is Responsible for your bill? ( ) Mine ( ) Other Driver
Copy of accident report? ( ) Yes ( ) No

Health & Lifestyle

Do you exercise? Yes / No How often? _____ day(s) per week
What activities? Walking Running/Jogging Weight Training Cycling Yoga Pilates Swimming Other: ________
Do you smoke? Yes / No How much? / How often? _____________________________________
Do you drink alcohol? Yes / No How much? / How often? _____________________________________
Do you drink coffee? Yes / No How much? / How often? _____________________________________
Do you take any supplements (i.e. vitamins, minerals, herbs) or Prescription Medications? Yes / No
If yes, please list: ____
____
____
Are you allergic to any Medications? Yes / No If yes, please list: ______________________________________
____

Height: ________ Weight: ________ Blood Pressure: ______/______

Other

Please list any health conditions not mentioned:
____
____

Please list any surgeries (include type of surgery and date it was performed): ____________________________
____
____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. Yes / No

Authorization of Care

I authorize and agree to allow the following doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercise for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which pre-existing, given by another healthcare practitioner, or are related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or his staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature: ____ Date: ___________
Patient's Name Printed: ____ Date: ___________

If the patient is legal charge limited capacity requiring guardianship for treatment, please complete the following:
Date Guardianship Awarded: ___________________ County, State of Guardianship__________________

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.
Guardian's Signature: ____ Date: ___________

In Case of Emergency

Name: ___________________________________ Relationship: ________________________
Phone #: __________________