MORRISON CHIROPRACTIC, P.A.

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Name:_____ Date/Time of Accident:_____

Please send any reports or other communication to my primary care provider:

_____ or other specialists I have seen: _____.

Please explain in detail how the accident happened:_____

_____

_____

Where did you feel pain immediately after the accident?:_____

List the extent of your injuries as you know them:_____

_____

Check the Symptoms that you have noticed since the accident:

__ Headache	__ Dizziness	__ Fatigue	__ Upset Stomach
__ Light Bothers Eyes	__ Neck Pain	__ Head Feels Too Heavy	__ Memory Loss
__ Ear Ringing	__ Stiff Neck	__ Cold Hands/Feet	__ Fainting
__ Face Flushed	__ Back Pain	__ Pins and Needles	__ Sleep Problems
__ Loss of Balance	__ Tension	__ Nervousness	__ Loss of Smell
__ Fever	__ Loss of Taste	__ Chest Pain	__ Cold Sweats
__ Shortness of Breath	Other:_____		

Were you wearing a seatbelt/shoulder harness? __ Yes __ No

Did Airbag deploy? __ Yes __ No

Did you strike your head on any part of the vehicle? __ Yes __ No

Did you lose consciousness? __ Yes __ No

Was your head turned left or right at impact? __ Yes __ No

Was your car: ☐Stopped ☐Rolling ☐Moving with traffic?

Was your foot on the brake? __ Yes __ No

Where were you taken after the accident? _____

How were you taken there? ☐Ambulance ☐Drove Self ☐Driven by Someone

Were you Hospitalized? __ Yes __ No

If yes, How long were you admitted?_____

Name of Hospital/Doctor?_____

What Treatment was given?_____

Was any other doctor consulted? If yes, Who?_____

What was the 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? __ Yes __ No

If so, what was the complaint?_____

Are your work/daily activities restricted as a result of the accident? __ Yes __ No

Since your injury are your symptoms: ☐Improving ☐Getting Worse ☐Staying the Same

Signature:_____ Date:_____

PERSONAL INJURY
AUTO/ATTORNEY INFORMATION

Ellicott City • 410.465.0555 | 2850 N. Ridge Road, Ellicott City, MD 21043
Clarksville • 410.531.9985 | 6363 Ten Oaks Road, Clarksville, MD 21029
www.morrisonchiropractic.com

MORRISON CHIROPRACTIC, P.A.

Patient Name: _____ Date of Accident:_____

Patient's Policy:_____

Insured's Name:_____

Has PIP been: ☐Filed? ☐Exhausted? ☐Waived? Date: _____

Insurance Carrier: _____

Claim #:_____ Adjustor:_____ Phone #:_____

Claim Address:_____

_____

Attorney Name:_____ Phone #:_____

Address:_____

_____

FOR OFFICE USE ONLY

Initial Report Date:_____ Mailed: _____

Interim Reports Date:_____ Mailed:_____

_____ _____

_____ _____

_____ _____

Discharge Date: _____ Final Report Date:_____ Final Bill Date:_____

_____ Assignment of Benefits/Lien Signed by Patient/Attorney

Notes:

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