NATURAL HEALTH CENTER, P.C.

AUTO ACCIDENT QUESTIONNAIRE

Dear Patient:
We need this confidential information answered completely to help us assess your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

GENERAL INFORMATION:

NAME:_____ **DATE OF BIRTH** _____ **SS#** _____

NATURE OF AUTO ACCIDENT – Please explain in detail how your accident happened:

1. What was the time and date of this present injury? ____ AM ___ PM _____ , 2000
2. City:_____ State:_____
3. Please explain in detail how your accident happened. (Please include location and Conditions.)_____

   _____

   _____

   _____

   You were heading □ North □ East □ South □ West on _____ (street or highway)

   Other vehicle was headed □ North □ East □ South □ West on _____ (street or highway)

   Were police notified? □ Yes □ No - You were struck from □ Behind □ Front □ Left Side □ Right Side

   You were □ Driver □ Passenger □ Front Seat □ Back Seat □ Using Seat Belts □ Other Protective Devices
4. Did you come in contact with any objects? _____ If yes, what objects (e.g., door, steering wheel, etc.)?

   _____
5. What parts of your body came in contact with the above object(s)? _____
6. Where did you feel pain or unusual feeling immediately after the accident? _____

   _____
7. Were you unconscious as a result of the injury? ____ If yes, how long? _____
8. Were you bleeding as a result of the injury? _____
9. Were you taken to the hospital after the accident? _____ By Ambulance? ____ If so, where? _____

   Treating Doctor's name: _____ ____DC ____MD ____DO ____DDS
10. Describe the doctor's diagnosis:--------_____
11. What treatment did you receive? _____
12. Are you still under a doctor's care? _____ If yes, please explain: _____

    _____

    _____

Past History:

1. Have you ever injured this area before?_____ If yes, when?_____
2. If injured before, did you lose time from work?_____
3. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? ____ If yes, please explain dates and details? _____

   _____

(continued on Back)

4. Have you been treated previously by a chiropractor? ____ If yes, please explain? _____

_____

Present Information/Disability:

1. Did you lose any time from work? _____ If yes, date of lost time: _____
2. Have you returned to work? _____ If yes, date returned to work? _____
3. Job description: _____
4. Are your work activities restricted as a result of this accident? _____
5. Do you have to favor any part of your body in your work? _____If yes, please explain? _____
6. Since this injury, are your symptoms: improving _____, getting worse _____, or the same? _____
   Please explain? _____

   _____
7. Do any diseases or accidents affect your employment? _____ If yes, please explain? _____

   _____

Insurance Information:

Your Insurance Information

1. NAME OF DRIVER OF VEHICLE **IN WHICH** YOU WERE INJURED. (IF APPLICABLE) _____

   INSURANCE CO.: _____ AGENT'S NAME, & PHONE _____

   POLICY # : _____ CLAIM #: _____

OTHER CARS INSURANCE:

2. NAME OF DRIVER OF OTHER VEHICLE (IF ANY): _____

   INSURANCE CO.: _____ PHONE #: _____

   POLICY HOLDER: _____ POLICY # _____

   CLAIM #: _____ ADJUSTER: _____

LEGAL REPRESENTATION:

1. Have you retained an attorney? _____ If yes, Name _____

   Address _____ Phone#: _____

I verify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature (Upon review) Date

(NH Auto Form 3/17/03)