Hessler Chiropractic
279 W Capac Road
Imlay City, MI 48444

P: (810) 724-0596
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Hesslerchiro.com

# Hessler Chiropractic

## Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ____/____/____

Date of Exam: ____/____/____ Provider: Dr. Joel Hessler New Patient □ Yes □ No

**Basic Information about the Accident:**

Date Accident Occurred or Started: ____/____/____ Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place:
_____
_____
_____
_____
_____

Describe the condition or symptoms caused by the Accident:
_____
_____
_____
_____
_____

**Auto-Accident Specific Information:**

Were you the: □ Driver □ Passenger □ Pedestrian □ Bicyclist
Automobile you were in: Year _____ Make _____ Model _____
Damage to your car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender
Damage Amount Estimate: $_____ : □ Minor □ Major □ Totaled □ Moderate □ Unsure
Other Automobile: Year _____ Make _____ Model _____
Damage to other car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender
□ Minor □ Major □ Totaled □ Moderate □ Unsure
Where did the accident happen? Street Names: _____ City/State _____
Was it? □ Controlled Intersection □ Uncontrolled □ Not Intersection
Was there a traffic light? □ None □ Green □ Red □ Turn Arrow □ Stop Sign
Were you: □ Slowly Moving □ Moving □ Stopped
Weather Conditions: □ Sunny □ Rainy □ Cloudy
Street Surface: □ Dry □ Wet □ Slick □ Icy □ Pavement □ Other _____

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Type of Impact: □ Rear end □ Front □ Side Impact □ Roll Over
Brakes on Impact: □ Locked Tight □ Loosely Applied □ Foot not on brake
How far did your car move? □ Did not move □ Moved 1-5 ft □ Moved 6-10 ft □ Moved over 10 ft
Where were you seated in the vehicle: _____ Wearing Seat belt? □ Yes □ No
Shoulder harness: □ Yes □ No Headrest: □ Yes □ No Headrest Position: □ Up □ Down
Is the car equipped with airbags? □ Yes □ No Did they deploy? □ Yes □ No
Did you see the impact coming? □ Yes □ No Did you brace yourself for impact? □ Yes □ No
On impact, your head was looking: □ Ahead □ Behind □ Up □ Down □ To the Right □ To the Left
On impact were you: □ Thrown forward □ Thrown backwards □ Thrown sideways □ Other
_____
Did your body hit anything inside the car? □ Yes □ No Body Part: _____
What did it hit? _____
Head trauma? □ Yes □ No Loss of Consciousness? □ Yes □ No For how long? _____
Do you remember the accident happening? □ Yes □ No
Hospital? □ Yes □ No Name of hospital: _____ How long there?
_____
Taken by ambulance? □ Yes □ No
X-rays taken? □ Yes □ No X-ray areas: □ Neck □ Mid-back □ Low-back □ Other X-rays
_____
Medication Given? □ Yes □ No RX:
_____
Other instruction: _____ Follow-up:
_____

**Additional Information Related to the Condition:**

Describe your pain: □ Sharp □ Dull □ Stabbing □ Aching □ Radiating □ Burning □ Throbbing □ Numbness
What caused it?
_____
What aggravates it?
_____
What relieves it?
_____
_
Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? □ Yes □ No
When? ____/____/____
Describe:
_____
_____
_____
_____
_____
_____
_____
_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

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| Name | Type of Licensure | Date of Last Visit |
|---|---|---|
| _____ | _____ | ____/____/____ |
| _____ | _____ | ____/____/____ |

Have you missed work or school due to your injuries? □ Yes □ No
Do you smoke? □ Yes □ No Number of packs: _____
Do you drink alcohol? □ Yes □ No Number of Drinks _____

Notes:
_____
_____
_____
_____
_____
_____
_____
_____

**Medical History:**

Have you ever been in our office before? □ Yes □ No
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ____/____/____
2) _____ ____/____/____
3) _____ ____/____/____

Surgeries/Hospitalizations:
_____

Allergies (please list all):
_____

List all medications you are now taking and why: _____