CHIROPRACTIC ASSOCIATES CLINIC

SGI MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Patient's Name: ____ Date: __ __ __ __ __ __
MM DD YY

SGI Claim #: ___________ Date of Accident: __ __ __ __ __ __
MM DD YY

Adjuster: _______________________________

Where did the accident occur? ____

Were you driving at the time of the accident? ☐ Yes ☐ No

What kind of vehicle do you drive? ____

What kind of vehicle struck you/did you strike? ____

Upon impact, your car was: ☐ Stopped ☐ Moving ☐ Turning right ☐ Turning left

Where was the damage on your vehicle? ☐ Left front ☐ Right front

☐ Left side ☐ Right side

☐ Left rear ☐ Right rear

What was the estimated speed of impact? ____

Did you see the accident coming? ☐ Yes ☐ No

Did you have a seat belt on? ☐ Yes ☐ No

Upon impact, which way were your thrown? ____

Upon impact, what did you experience? ____

When did you first experience your symptoms? ____

Were you able to get out of the vehicle and walk? ____

Were you conscious at all times? ☐ Yes ☐ No

Could you move all parts of your body? ☐ Yes ☐ No

Was an ambulance called for you? ☐ Yes ☐ No

Did you go to the Hospital, or to a clinic? ☐ Yes ☐ No Date: __ __ __ __ __ __
MM DD YY

If so, place: ________________ Attending Physician:______________________

Was there any imaging done? ☐ X-ray ☐ MRI ☐ CT Scan

If so, at what location? ____

Was there any medication prescribed? ☐ Yes ☐ No

If so, what was prescribed? ____

Have you consulted another physician? ☐ Yes ☐ No

If so, Physician name: ____

Were you able to sleep that night? ☐ Yes ☐ No

What symptoms have you experienced as a result of the accident? ________________________________

____

Did you take time off work? ☐ Yes ☐ No

If so, what dates have you taken off? ____

Are you able to perform your work duties? ☐ Yes ☐ No

If no, please describe what you are having difficulty with: ______________________________

____

Are you able to perform your activities of daily living? ☐ Yes ☐ No

If no, please describe what you are having difficulty with: ______________________________

____

List any prior motor vehicle accidents, and the date(s) they occurred: ______________________________

____

Describe any pre-existing or unrelated conditions: ____

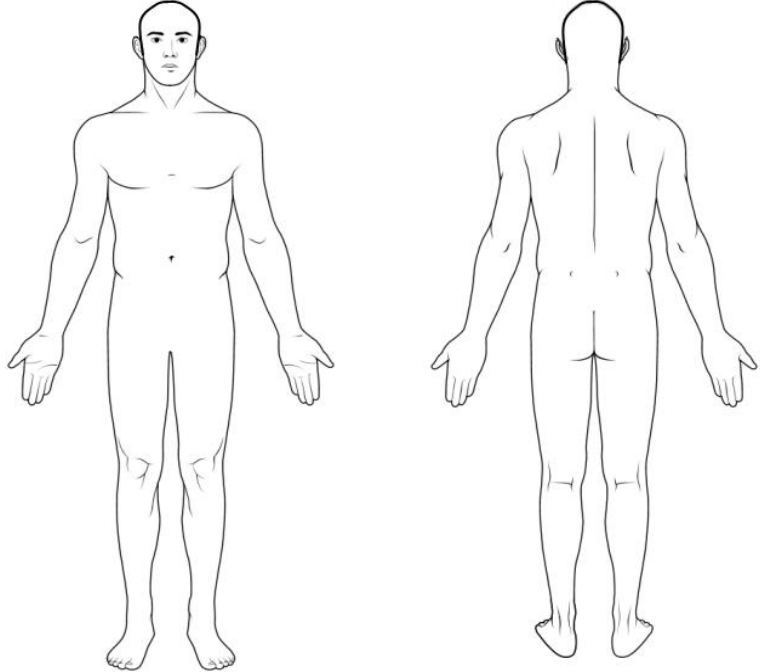
____

PAIN QUESTIONNAIRES

Body Pain Diagram

Please fill this out carefully. Use the appropriate symbols (provided below) to mark the area on the diagram where you feel the described sensation. Include all affected areas, including radiation of pain.

Numbness	= = =
Burning Pain	x x x
Aching Pain	(((
Pins & Needles	o o o
Stabbing Pain	/ / /



Visual Analog Scale

If you had to rate your pain on a scale of 0 - 10, (0 = no pain, 10 = most pain imaginable), where would you rate your pain right now? Please indicate on this scale with a check or circle.

____

0 1 2 3 4 5 6 7 8 9 10

______________________________ ______________________________

Date Signature