

## AUTO INJURY QUESTIONNAIRE

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
 Email \_\_\_\_\_ Who referred you to us? \_\_\_\_\_  
 Marital Status  M  S  D  W Number of Children \_\_\_\_\_ Are you Pregnant?  Yes  No  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_ Full Time / Part Time  
 Employers Name \_\_\_\_\_ Employers Address \_\_\_\_\_  
 Your Auto Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agents Name \_\_\_\_\_  
 Do you have Med Pay on Policy?  Yes  No  Unknown Do you have health insurance?  Yes  No

### NATURE OF ACCIDENT:

1. Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_
2. In your own words, briefly describe the accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Were you  Driver  Front Passenger  Left rear passenger  Right rear passenger  Other \_\_\_\_\_
4. Who hit who/what?  You hit other vehicle  Other vehicle hit you  You hit object \_\_\_\_\_
5. Point of impact  Head-on  Left Front  Right Front  Rear-End  Left Rear  Right Rear
6. Your vehicle type  Car  Van  Station Wagon  Pick-up truck  SUV  Other \_\_\_\_\_
7. What was your vehicle doing at the time of the accident?  Stopped at an intersection  
 Stopped in traffic  Stopped at light  Making a right turn  Making a left turn  Parking  
 Proceeding along  Slowing down  Accelerating  Other \_\_\_\_\_
8. The other vehicle type  Car  Van  Station Wagon  Pick-up truck  SUV  Other \_\_\_\_\_
9. What was the other vehicle doing at the time of the accident?  Stopped at an intersection  
 Stopped in traffic  Stopped at light  Making a right turn  Making a left turn  Parking  
 Proceeding along  Slowing down  Accelerating  Other \_\_\_\_\_
10. Did you have a seat belt on?  Yes  No Did you have a shoulder harness on?  Yes  No
11. What was the direction of your head at time of impact?  Straight  Turned Right  Turned Left
12. How many people were in the car with you?  None  One  Two  Three  Four  Other \_\_\_\_\_
13. Time of Accident \_\_\_\_\_ Road conditions at time of accident  Icy  Wet  Sandy  Dark  Clean and Dry
14. Visibility at time of Accident  Poor  Fair  Good
15. What was the position your headrest at time of impact?  Up  Down  Unknown  No head rests
16. Was the head restraint position altered by the impact?  Yes  No  Unknown
17. Did driver side air bags deploy?  Yes  No Did passenger side airbags deploy  Yes  No
18. What was your hand position on the steering wheel?  Both hands on  One hand on  Do not recall
19. Did you have pressure on the brakes?  Yes  No  Do not recall
20. Did you see the accident coming?  Yes  No Were you braced for the impact?  Yes  No
21. Did your body strike the inside of your vehicle?  Yes  No \*If yes, what part of your  
 body? \_\_\_\_\_ hit what part of the vehicle? \_\_\_\_\_
22. Did your vehicle hit anything else after the crash? \_\_\_\_\_
23. Did you lose consciousness during the injury  Yes  No \*If yes, how long \_\_\_\_\_
24. Did the police show up at the scene?  Yes  No Was a report filed?  Yes  No
25. Where did you go after the accident?  Home  Work  Hospital ER  Private Doctor
26. How did you get there?  Drove self  Somebody else  Ambulance  Police  Other \_\_\_\_\_
27. Check off your symptoms right after and/or a few days following:
 

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Anxious	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sleep trouble
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Confusion	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Fainting	<input type="checkbox"/> Depression	<input type="checkbox"/> Pain behind eyes	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Hand numbness
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Toe numbness	<input type="checkbox"/> Irritability	<input type="checkbox"/> Other _____
28. If you went to the hospital, were x-rays done?  Yes  No Was lab work done?  Yes  No  
 Body parts x-rayed? \_\_\_\_\_ X-rays revealed? \_\_\_\_\_  
 Lab work revealed? \_\_\_\_\_
29. Treatments:  Cervical collar  Ice  Medications \_\_\_\_\_  Other \_\_\_\_\_

**Primary Complaint:** \_\_\_\_\_

Symptoms appeared:  Gradually  Suddenly

How long have you had this pain? \_\_\_\_\_ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain:

Aching  Burning  Diffused  Dull  Numbness  Sharp

Shooting  Throbbing  Tightness  Tingling

How frequently do you have this pain? (Check one below):

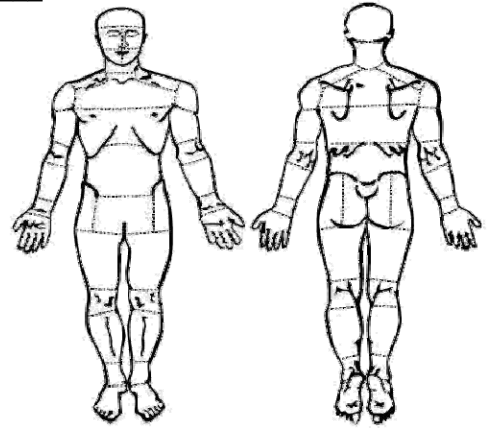
Constant  Frequent  Intermittent  Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? \_\_\_\_\_



**Additional Complaint:** \_\_\_\_\_

Symptoms appeared:  Gradually  Suddenly

How long have you had this pain? \_\_\_\_\_ Years / Months / Weeks / Days

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain:

Aching  Burning  Diffused  Dull  Numbness  Sharp

Shooting  Throbbing  Tightness  Tingling

How frequently do you have this pain? (Check one below):

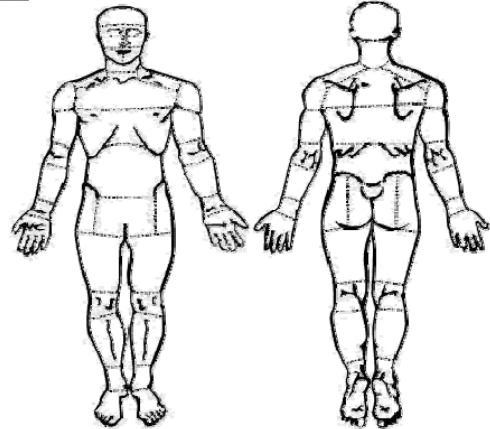
Constant  Frequent  Intermittent  Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? \_\_\_\_\_



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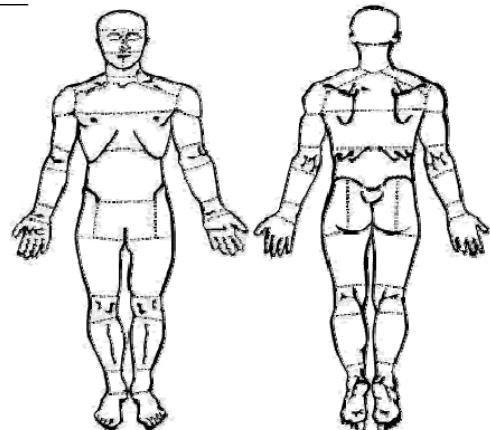
Constant  Frequent  Intermittent  Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? \_\_\_\_\_



**HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION?**

1) Name \_\_\_\_\_  
Phone # \_\_\_\_\_  
Dates of care \_\_\_\_\_  
Tests/Treatments \_\_\_\_\_  
Results \_\_\_\_\_

2) Name \_\_\_\_\_  
Phone # \_\_\_\_\_  
Dates of care \_\_\_\_\_  
Tests/Treatments \_\_\_\_\_  
Results \_\_\_\_\_

**Prior Similar Symptoms:**

- I have NOT had prior symptoms similar to my current
- My current complaints DID exist before, but have not been
- My current complaints ALREADY existed and were worsened

**Has your history contributed to your current**

- My history HAS contributed to my current symptoms
- My history HAS NOT contributed to my current
- I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred...

Months ago /  Years ago or on date: \_\_\_/\_\_\_/\_\_\_

Write in any prior symptom history, not covered above:

\_\_\_\_\_

**\*Please check all conditions below that you currently have or have had in the past\***

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Heartburn/Acid reflux | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Prostate Problems    |
| <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Migraine Headaches       | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Heart Palpitations    | <input type="checkbox"/> Miscarriage              | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergy Shots          | <input type="checkbox"/> Depression            | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Mononucleosis            | <input type="checkbox"/> Ringing in the Ears  |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Multiple Sclerosis       | <input type="checkbox"/> Sinusitis            |
| <input type="checkbox"/> Appendicitis           | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Herniated Disc        | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Sleeping Problems    |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Nervousness/Anxiety      | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Asthma/Short of breath | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Eating Disorder       | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Breast Lump            | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> IBS                   | <input type="checkbox"/> Parkinson's Disease      | <input type="checkbox"/> Tumors/Growths       |
| <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Pinched Nerve            | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Upset Stomach        |
| <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Measles               | <input type="checkbox"/> Polio                    | <input type="checkbox"/> Vaginal Infections   |

Any other conditions not listed above: \_\_\_\_\_

**PLEASE LIST ALL SURGERIES YOU HAVE HAD**

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

**PLEASE LIST ANY PREVIOUS ACCIDENTS/FALLS**

What \_\_\_\_\_ When \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_  
Remarks \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE**

What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_  
What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_  
What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_

**OCCUPATIONAL INFORMATION**

Job Involves:  
 Sitting  Standing  Desk  Counter  Other \_\_\_\_\_ How long? \_\_\_\_\_  
 Lifting How much weight? \_\_\_\_\_  Bending  Stooping  Twisting  Turning  
Type of shoes  High heels  Boots  Arch supports  Other \_\_\_\_\_  
How long do you speak on the telephone each day? \_\_\_\_\_  Traditional telephone receiver  Headset  
Physical activity at work:  Sedentary  Light manual labor  Manual labor  Heavy manual labor  
Do any of your work activities aggravate your present main complaints? Please describe:  
\_\_\_\_\_

**HOW HAS THIS AFFECTED YOUR LIFE?**

Circle one

- Have you missed work? YES NO If yes, how long? \_\_\_\_\_
  - Has the quality of your work been affected? YES NO
  - Are you able to do household chores? YES NO
  - Has this problem interfered with your social life? YES NO
  - Has it interfered with spending time with family and friends? YES NO
  - Has it interfered with your recreational activities? (Exercise, Golf, Tennis, etc.) YES NO
- Please list any other daily activities/duties that are difficult for you due to the pain you're having.
- 

**DISABILITY**

Do you have a permanent disability rating? \_\_\_\_\_ Location \_\_\_\_\_ Date received \_\_\_\_\_  
 Rating Percentage \_\_\_\_\_

**HEALTH HABITS:**

- Smoking: \_\_\_\_\_ Packs per Week       Alcohol: \_\_\_\_\_ Drinks per Week
- Coffee/Caffeine: \_\_\_\_\_ Drinks per Week       High Stress Level: High/ Moderate/ Low Reason: \_\_\_\_\_
- Other Chemical Dependencies: \_\_\_\_\_

**Exercise:**  None  Moderate  Daily  Heavy

**Sleep:** Hours per night \_\_\_\_\_ Type of mattress \_\_\_\_\_ Naps \_\_\_\_\_

Do you sleep on your  Back  Side  Stomach

Please describe your sleep (ex. deep/restful, interrupted, etc.) \_\_\_\_\_

Any special diets? \_\_\_\_\_

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**I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.**

✕

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Terms of Acceptance**

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

**To Locate, Analyze and Correct Spinal Interference to the Nervous System.** The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference,) in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote natural health.

**WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.**

**WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.**

**WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).**

**THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!**

I, having read the above statement and understanding it fully, do undertake chiropractic health care on this basis.

✕

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I indicate that a copy of Jenkins Chiropractic Notice of Privacy Practices has been made available to me and understand that my signature indicates my consent to the use and disclosure of protected health information by Jenkins Chiropractic as described in that notice.

✕

\_\_\_\_\_  
Signature  
(Legal Guardian's Signature if Minor)

\_\_\_\_\_  
Date