



Twisted Spine & Joint
— Dr. Bryan Stanton —

AUTO ACCIDENT QUESTIONNAIRE

General Information:

Name Sex Marital Status Date of Birth
Address City State Zip
Home # Work# Cell#
Social Security #

Nature of Accident:

What was the date and time of this present injury? Date: Time: AM/PM

Please explain in detail how your accident happened.

Were you the driver passenger back seat driver's side back seat passenger side?

What direction was you headed? North south east west

What direction was the other vehicle headed? North south east west

Were you struck from behind front left side right side

Were you wearing a seat belt? ☒ YES ☐ NO

Did you come in contact with any objects in the car? ☒ YES ☐ NO
If yes, what? (i.e., windshield, steering wheel, etc.)

What parts of your body came in contact with the above object?

Were you unconscious as a result of the injury? ☒ YES ☐ NO

Were there any other passengers in the vehicle at the time of the accident? ☒ YES ☐ NO If yes, who and what are their ages and relationship to you?

Were the police called to the scene? ☒ YES ☐ NO Was an accident report taken? ☒ YES ☐ NO If yes, please provide a copy of the accident report for our files.

Were you taken to the hospital following the accident? ☒ YES ☐ NO By Ambulance? ☒ YES ☐ NO

Was any other doctor consulted after your accident? ☒ YES ☐ NO If yes, doctor's name?

Describe the doctor's diagnosis and treatment you received. _____

Are you still under a doctor's care: ☒ YES ☐ NO If yes, please explain. _____

Past History:

Have you ever injured this area before?: ☒ YES ☐ NO If yes, when? _____

Have you been involved in any previous accidents of any kind (personal injury, automobile accident, workers compensation)? ☒ YES ☐ NO If yes, please explain dates and details _____

Have you been treated previously by a Chiropractor? ☒ YES ☐ NO If yes, please explain _____

Have you enjoyed good health prior to this accident? ☒ YES ☐ NO If no, please explain (illness/injuries) _____

Present Information/Disability:

Have you returned to work? ☒ YES ☐ NO If yes, date you returned _____

Job description: _____

Are your work activities restricted due to this accident? ☒ YES ☐ NO If yes, explain _____

Do you notice any activity restrictions as a result of the injury? ☒ YES ☐ NO If yes, describe _____

Since this injury, are your symptoms _____ improving _____ getting worse _____ or the same? Explain: _____

Legal Representation:

Have you retained an attorney? ☒ YES ☐ NO If yes, give name, address and phone number _____

I certify 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.

I authorize the doctors at Twisted Spine & Joint to perform upon me diagnostic and/or therapeutic procedures arising from my current or presently unforeseen conditions, which the doctor may consider necessary or advisable in the course of my health.

Patient Signature

Date