DONAHUE CHIROPRACTIC

Auto Accident Questionnaire

Name_____ Date_____

Date of Accident_____

Brief description of Accident (i.e. rear-ended, head on, side impact, etc.) _____

_____

_____

Describe any secondary collisions (i.e. pushed into vehicle in front of you) _____

_____

Do you recall striking anything inside the vehicle? (i.e. knees on dashboard, head on windshield)

☐ NO ☐ YES _____

What type of vehicle were you in? _____ Estimated Speed_____

What type of vehicle was the other driver in ?_____ Estimated Speed_____

Describe damage to your vehicle ☐ Light ☐ Moderate ☐ Heavy ☐ Damage Estimate _____

After the accident was your vehicle ☐ Drivable ☐ Not drivable

Were you ☐ Driver ☐ Passenger - Sitting:_____

At the time of the accident: Visibility was ☐ Good ☐ Poor

Time of Day ☐ Daylight ☐ Night

Road conditions ☐ Dry ☐ Wet ☐ Snow/Ice

At the time of impact:

Were you looking ☐ Toward Left ☐ Straight ahead ☐ Toward Right ☐ Up ☐ Down

Was your foot on the brake? ☐ Yes ☐ No

Were you ☐ Braced for Impact ☐ Unaware of Impending collision

Were you wearing a seatbelt? ☐ Yes ☐ No Did your airbag deploy? ☐ Yes ☐ No

Was your headrest ☐ Adjusted properly ☐ Not Adjusted ☐ Don't Recall

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name **SDASD**_____ Phone # _____

Attorney Name _____ Phone # _____

Stop Here. Lower section for doctor's evaluation

_____

MIC1 Subjective symptoms	10pts.
MIC2 Symptoms, Loss of ROM	50pts.
MIC3 Symptoms, ROM & Neuro	90pts.

Modifiers

10-30	Excellent
35-70	Good
75-100	Poor
105-125	Guarded
130-165	Unstable

Canal Size	10-12 mm	20
Canal Size	13-15 mm	15
Kyphotic Cervical Curve		15
Straightened Cervical Curve		10
Blocked/ Fused Segments		15
Loss of Consciousness		15
Pre-existing DJD		10

Hyper/Hypo Mobility on Flex./Ext.

Complicating Health/Lifestyle Factors:

_____

_____

_____