Dr. Kathy Pansegrau, DC
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360°
CHIROPRACTIC
We've Got Your Back

Health Information and Health History

Auto Accident Questionnaire

Date of accident: _____

Time of accident: _____

To your knowledge what caused the accident? _____

_____

What occurred following the accident? Circle all that apply

Received emergency care Felt confused Felt nervous Felt weak

Loss of consciousness Transported to the hospital via ambulance

After accident you were taken to? _____

Position occupied in vehicle? Driver Front seat passenger Back seat passenger

Were you wearing seat belt? Yes No

Was the accident: Expected Complete surprise

How was your vehicle struck? Front end Rear end Right side Left side

Did the air bags deploy? Yes No Did the seat break? Yes No

Did your vehicle have headrest? Yes No

What speed were you traveling? _____ What speed was the other vehicle traveling? _____

What type of vehicle were you in? _____Type of other vehicle involved? _____

Was visibility? Poor Good

What was the condition of the roadway? Wet Dry Other: _____

Where did you feel pain immediately following the accident? _____

_____

Do you or did you have any visible abrasions? Yes No Where? _____

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What type of treatment have you had since the accident? _____

_____

Are you taking medication due to injuries from this accident? Yes No If yes, what type? _____

Where x-rays or special test performed following the accident? Yes No If yes, please list name or facility where tests were performed : _____

_____

Do you have additional symptoms or complaints that have occurred since the accident? Yes No
If yes, please list:_____

Is there any additional information you would like for us to know? _____
_____
_____
_____

Doctor's notes: _____
_____
_____
_____

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Work Injury Questionnaire

Date of injury? _____

Time of injury? _____

Did you report this injury to your employer? Yes No Who did you report it to? _____

What caused the injury? _____

_____

Describe in your words what happened? _____

_____

_____

_____

What is your major complaint? _____

_____

_____

Do you have any secondary complaints as a result of this accident? _____

_____

_____

Have you missed work due to this injury? Yes No How many days? _____

Describe your job duties: _____

_____

Additional information: _____

_____

Doctor's Notes: _____

_____