**Dr. James E. Hollingsworth**
- Chiropractic Physician
- Diplomate American Academy of Pain Management
- Clinical Member American Psychotherapy and Medical Hypnosis Association

HELPING YOU EXCEL

# Automobile Accident Questionnaire

Please answer all questions completely

Name_____ Social Security #_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail Address_____

Date of Birth _____ Age_____ Marital Status M S W D (circle one) Gender M F (circle one)

Occupation_____ Employer Name_____

Employer's Address_____ Employer Phone_____

Referred to our office by_____ Address_____

Please explain in detail how the accident happened:_____

_____

_____

**Information about the vehicle in which you were injured:**

Driver's Name _____ Insurance Company_____

Insurance Address_____

Insurance Contact Person_____ Phone _____

Policy Number_____ Claim Number_____

**Information about other vehicle involved (if applicable):**

Driver's Name _____ Insurance Company_____

Insurance Address_____

Insurance Contact Person_____ Phone _____

Policy Number_____ Claim Number_____

Were police notified? Yes No Have you retained an attorney? Yes No Not Yet

Attorney's name, address, and phone_____

Accident date and time ___/___/_____ at _____ A.M. P.M. Number of people in your vehicle _____

Your vehicle was heading North South East West on _____ (street or highway)

Other vehicle was heading North South East West on _____ (street or highway)

Did head strike windshield or object? Yes No Were you knocked unconscious? Yes No How long? _____

You were struck from Behind Front Left Side Right Side

You were Driver Passenger / Front Seat Back Seat / Using seat belts Other protective devices

You felt pain Immediately Later that day Next day Other _____

Where did you feel pain immediately after the accident?_____

Where were you taken after the accident?_____ Was treatment given? Yes No

Was any doctor consulted after the accident? Yes No

Doctor's name _____ D.C. M.D. D.O. D.D.S

Doctor's diagnosis_____ Was treatment given? Yes No

How often did you see the doctor? _____ How long did you see the doctor? _____

Have you ever had complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since the accident, your symptoms are Improving Getting worse The same

Please Complete Other Side

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# Health Questionnaire

Please answer all questions completely

Please check mark each of the conditions below that you are currently experiencing.

Name_____ Date_____

## Musculo Skeletal System

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## Genito-Urinary System

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

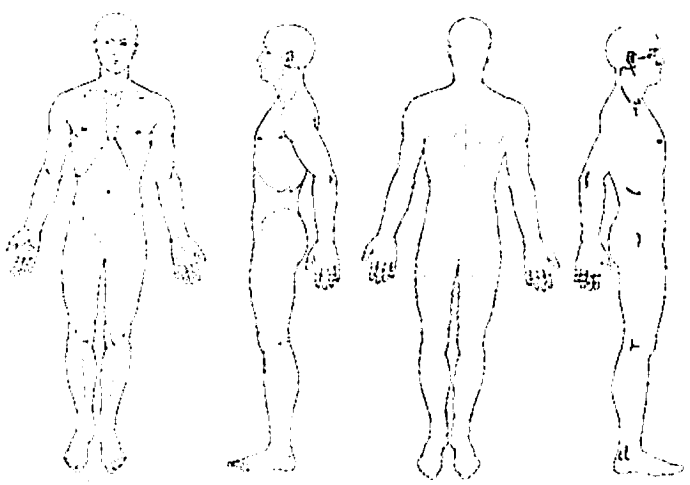
### Female

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

### Are You Pregnant?

Yes No

Please label areas of discomfort with the appropriate letter.



P: Pain N: Numb S: Spasm T: Tender H: Hypothesia

## Gastro-Intestinal System

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## Nervous System

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## Cardio-Vascular Respiratory

- Chest pain
- Pain over heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## Eye. Ear. Nose and Throat

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus problems
- Allergies
- Jaw pain

Patient's Signature _____

----------Do Not Write Below This Line----------

Patient accepted? Yes No Doctor's Signature: _____