



6769 COURTLAND DRIVE, SUITE 100  
ROCKFORD, MICHIGAN 49341

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# Automobile Accident Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Accident \_\_\_\_\_

Time of Accident \_\_\_\_\_

Place of Accident \_\_\_\_\_

History of Accident and Injury \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you heading (circle one)      N      S      E      W

Other vehicle was heading (circle one)      N      S      E      W

Road conditions were (circle one)      wet      dry      icy      snow

Approximate speed of your vehicle \_\_\_\_\_

Were you the (circle one) Driver or Passenger?

Were you wearing your seatbelt?                      Yes      No

Are you able to perform routine household chores?      Yes      No

If No, Please explain limitations \_\_\_\_\_

\_\_\_\_\_

Have you been unable to work due to this accident?      Yes      No

If Yes, From \_\_\_\_\_ To \_\_\_\_\_

Were you hospitalized?                      Yes      No

If so, what hospital? \_\_\_\_\_

# AUTO QUESTIONNAIRE:

## Health Insurance Information:

Name of Insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Telephone # \_\_\_\_\_

## Auto Insurance Information:

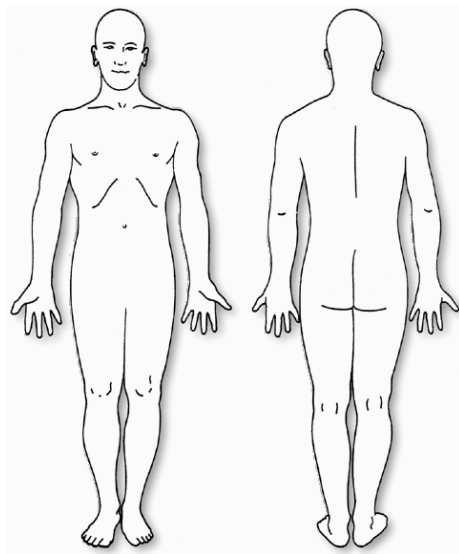
Name of Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Telephone # \_\_\_\_\_

Policy Number \_\_\_\_\_ Claim Number \_\_\_\_\_

Please mark your areas of discomfort on the figures below:



Patient's Signature \_\_\_\_\_

.....Do Not Write Below This Line.....

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Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_