KARE
CHIROPRACTIC
"Because We Care About Your Health"

Auto Injury Questionnaire

Date of Accident: _____

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

_____

_____

Describe any secondary collision (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):

☐ Yes ☐ No If yes, please describe: _____

_____

Did you lose consciousness? ☐ Yes ☐ No Were you taken to the hospital? ☐ Yes ☐ No

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: ☐ Driveable ☐ Not Drivable

Were you: ☐ Driver ☐ Passenger-Sitting: _____

At the time of accident: Visability was: ☐ Good ☐ Poor Time of Day: ☐ Daylight ☐ Night

Road conditions: ☐ Dry ☐ Wet ☐ Ice/Snow Time of Impact: _____

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

As your foot on the brake? ☐ Yes ☐ No

Were you: ☐ Braced for Impact ☐ Unaware of Impedning Collision

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

Was your headrest: ☐ Adjusted properly ☐ Not adjusted properly ☐ Don't recall

Your Auto Policy Insurance Name: _____

Claim #: _____ Adjuster Phone #: _____

Party at Fault's Auto Policy Insurance Name: _____

Claim #: _____ Adjuster Phone #: _____

Adjuster(*s*) Names: _____

Attorney Name(*if applicable*): _____ Phone #: _____

Patient Name(Print): _____

Parent/Guardian Name(Print): _____

Patient/Parent/Guardian Signature(X): _____ **Date:** _____