TUCKER CHIROPRACTIC CENTER
PO BOX 936 – GENTRY, AR 72734
479-736-8900

Auto Accident Questionnaire

Patient's Name _____ *Patient ID #* _____
Address where you live _____
Address where you get your mail (if different) _____
_____
*Birth Date:*_____ *Marital Status: M S W D*
Home Phone #: _____ *Cell Phone#:* _____
Preferred way to be contacted: Home or Cell May we leave a message? Yes or No
*Social Security #*_____
*Emergency contact name & phone #:*_____
*What are you ALLERGIC to?:*_____
Adverse reaction: _____
*Name of your Medical Physician:*_____
Are you presently under the care of your Medical Physician? Yes or No
Reason? _____

*Employer:*_____ *Phone #:*_____
*Address:*_____
City: _____ *State:* _____ *Zip:*_____
*Job title?*_____*How long have you worked there?*_____
*Describe your job duties:*_____
_____
Describe your activity level: ____Low ____Medium ____High
*What type of recreational activities do you enjoy?*_____
_____
*Have you ever had a spinal x-ray? Yes or No If yes, when?*_____
Did you have prior injuries or symptoms? Yes or No
*If yes, please explain:*_____
_____
*When did you last have a physical exam?*_____
*List any medications or vitamins that you routinely take:*_____
_____
_____
List any prior car accidents, hospitalizations, falls or other trauma and dates:
_____
_____
*List any serious illnesses and dates:*_____
_____
_____

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Auto Accident Questionnaire *Page 2*

*Patient's Name*_____ **Patient's ID #** _____
*Date and time of the accident:*_____ *Were the police notified? Yes or No*
Were you the Driver? ____Passenger?____ Pedestrian____
*Describe the accident in detail including the exact location:*_____

_____

_____

_____

*Did you go to the Hospital? Yes or No Name of Hospital:*_____
Have you seen any other doctor for treatment due to this accident? Yes or No
*If so, who?:*_____
Describe your injuries and symptoms that you are seeking chiropractic care for as a result of this accident: _____

_____

_____

On a scale of 0-10 (with 10 being the worst), rate pain you currently experience in your
*____Neck ____ Mid back ____ Low back ____ Other*_____
When is your pain the worst? ____Morning ____Afternoon ____Night

_____

What does your pain interfere with?____Work ____Sleep ____Daily Routine ____Recreation

_____

What activities aggravate your pain? ____Sitting ____Standing ____Walking ____Bending
____Lying down ____Driving ____Lifting

_____

Are you experiencing any ?____Numbness ____Tingling ____Radiating pain ____Burning
____Aching ____Tenderness ____Edema ____Muscle spasms

_____

Does anything help to relieve your symptoms? Yes or No
*If so, what helps?*_____
*List any medications you are taking as a result of the accident:*_____

_____

_____

Have you retained an attorney? Yes or No If yes, give name, phone # and address:

_____

*Did you return to work? Yes or No If no, how long were you off work?*_____
Did you return with any restrictions? Yes or No
*If yes, what were they?*_____

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Auto Accident Questionnaire

*Patient's Name*_____ **Patient's ID #** _____

Have you ever been diagnosed as having of suffering from? (Check all that apply)

__*Broken or Fractured Bones*	__*Osteoarthritis*	__*Eating disorder*
__*Circulatory Problems*	__*Epilepsy*	__*Alcoholism*
__*Rheumatoid Arthritis*	__*Pace Maker*	__*Drug Addiction*
__*Seizures/Convulsions*	__*Strokes*	__*HIV Positive*
__*A Congenital Disease*	__*Cancer*	__*Gall Bladder*
__*Excessive bleeding*	__*Ulcers*	__*Headaches*
__*High Blood Pressure*	__*Ruptures*	__*Depression*
__*Low Blood Pressure*	__*Coughing Blood*	__*Diabetes*

Family History of Disease:

__*Strokes*	__*Cancer*	___*Diabetes*
__*High Blood Pressure*	__*Heart Disease*	__*Kidney*
__*Low Blood Pressure*	__*Tuberculosis*	__*Anemia*

*Please explain anything checked above*_____

_____

_____

For women only: Are you pregnant? Yes or No ___ *# of pregnancies* ___ *# of children*
Would you like us to share your medical information with anyone? Yes or No
Who? _____
Would you like to share your financial account information with anyone? Yes or No
Who? _____

All information that has been given is current and true to my knowledge. I understand that it is my responsibility to notify Tucker Chiropractic Center of any changes to my insurance/payment information, and I understand that I am personally responsible for payment of services rendered. I have read the missed appointment policy and understand that not cancelling my appointment in a timely manner will result in a $15 charge.

I hereby give Tucker Chiropractic Center consent to treat me. I have been offered a copy of the HIPPA Notice of Privacy Practices that was provided by this office, and understand its terms.

Patient's Signature _____ *Date*_____

Updated 11/29/17

TUCKER CHIROPRACTIC CENTER
DR. GUY E. TUCKER D.C.
1179 S. Gentry Blvd.
P.O. Box 936
GENTRY, AR 72734

Telephone 479-736-8900

Auto Accident

1. Patient Name and Address _____

_____

2. Your Car Insurance _____

_____

3. Agent _____ *Telephone #*_____

4. Address _____

_____

5. Adjuster _____*Telephone #*_____

6. Address _____

_____

*Policy #*_____ *Claim #*_____

1. Name and Address of other driver involved in accident _____

_____

2. Car insurance of other driver _____

*3. Agent*_____ *Telephone #*_____

4. Address _____

_____

5. Adjuster _____ *Telephone #*_____

6. Address _____

_____

*Policy #*_____ *Claim #*_____