Provider: Helen Spieth LAc.

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Automobile Accident Injury Questionnaire

Insurance/ Account Information

Patient Name *(Please Print):*____

Insurance Companies Involved:

My Insurance Company: ____

Policy #:______________________________

Claim #:______________________________

Send Claims To

Claim Manager (PIP)/ Contact Person:________________________ **Phone #:**__________________

Mailing Address:____

____

Explanation of Accident

Date of the Accident: _____________ **Time:** ___________ **Location:** __________________________

Please describe the accident: ____

____

____

Did you report the accident? _______ **If so, to whom?** ___________________________________

Were you the *(circle one)***:** The Driver A Passenger A Pedestrian Cyclist

Were you struck from ***(circle one):*** Behind The Right The Left The Front

History of Injury

List the extent of your injuries as you know them: _______________________________________

____

Did you notice your symptoms immediately? If no, when did you first notice them? ________

____

Did you go to the hospital following the accident? ____________________________________

Circle any symptoms you have noticed since the accident:

Headaches Nervousness Stomach Upset Fatigue Neck Stiffness Irritability

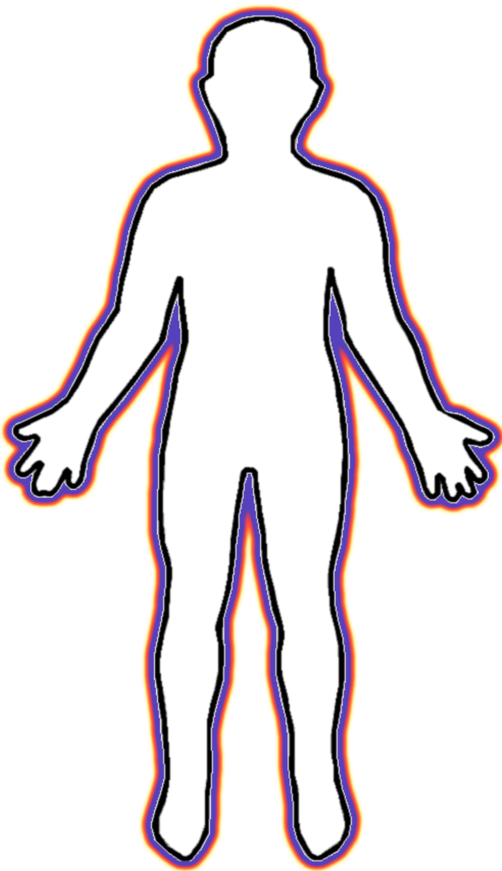
Neck Pain Tension Dizziness Depression Head Feel Heavy Diarrhea/ Constipation

Difficulty Sleeping Chest Pain Pins & Needles in arms & legs Shortness of Breath

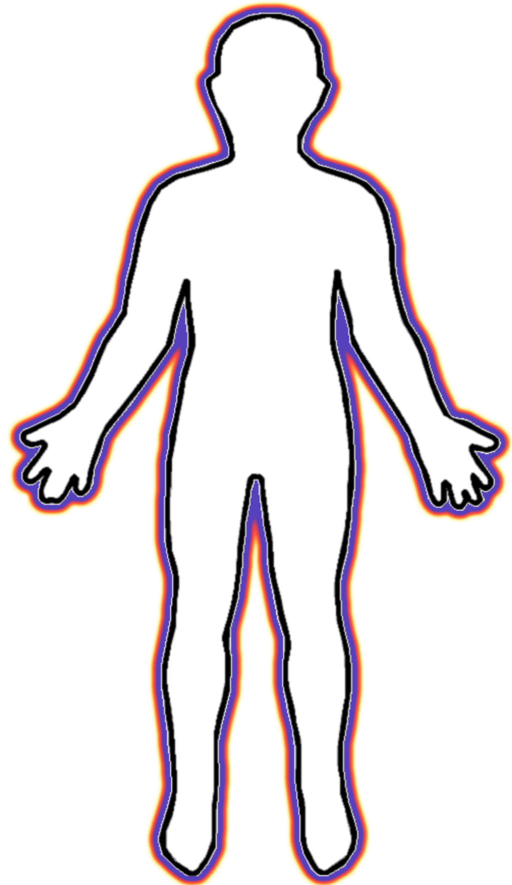
Back Pain Cold Sweats Numbness in Fingers & Toes Fever

Mark area of pain with an X or circle the area:

Front:



Back:



Patient Signature: ________________________________ Date: ________