

**Dr. Ricco Impastato, Chiropractor**

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_**

**Driver of vehicle in which you were injured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Claim#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Driver of other vehicle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adjuster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you retained an attorney? \_\_\_Yes \_\_\_\_No Attorney’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe the accident in detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were police notified? \_\_\_Yes \_\_\_ No**

**What was your position in the car? \_\_\_\_ Driver \_\_\_\_ Passenger**

**If passenger, where were you sitting in the car? \_\_\_ Front \_\_\_ Right Rear \_\_\_ Left Rear**

**What type of vehicle were you in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**You were heading? \_\_\_ North \_\_\_East \_\_\_ South \_\_\_ West on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(street or highway)**

**Other vehicle was headed? \_\_\_ North \_\_\_East \_\_\_ South \_\_\_ West on \_\_\_\_\_\_\_\_\_\_\_\_\_\_(street or highway)**

**Was the impact from the: \_\_\_ Front \_\_\_Right Side \_\_\_ Left Side \_\_\_ Rear**

**Was the vehicle in: \_\_\_Park \_\_\_Neutral\_\_\_ In Gear \_\_\_ Moving \_\_\_ Stopped**

**Were brakes being applied? \_\_\_ Was vehicle being shoved? \_\_\_ Forward \_\_\_ Backwards \_\_\_ Sideways**

**Were you shoved forward and whipped backwards at a rapid force, while hitting your head?\_\_\_\_\_\_\_\_\_\_**

**Did your head override headrest and springboard forward? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did your hat or glasses end up in the back seat or under the rear window? \_\_\_ Yes \_\_\_ No**

**Did any part of your body hit any part of the interior? \_\_\_ Console \_\_\_ Steering Wheel \_\_\_Dashboard \_\_\_Windshield \_\_\_ Arm Rest \_\_\_ Side Door Window \_\_\_ Part of Body**

**Parts of body: \_\_\_Chest \_\_\_Chin \_\_\_Knee \_\_\_ Shoulder \_\_\_ Hand \_\_\_ Head**

**Were you wearing your seatbelt? \_\_\_Yes \_\_\_ No Did they break upon impact? \_\_\_ Yes \_\_\_ No**

**Was the impact: \_\_Expected \_\_\_Unexpected If expected, did you brace for the impact? \_\_\_ Yes \_\_\_ No**

**If Yes, what did you brace against? \_\_\_ Did your seatbelt have a shoulder harness? \_\_\_Yes \_\_\_ No**

**Did it contribute to the pain? \_\_\_Yes \_\_\_No Which way was your head turned?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The headrest was? \_\_\_ Up \_\_\_Down How far was your head from the head rest at point of accident?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did the seat cushion your impact or spring you forward? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**At the point of impact, where did you experience the pain sensation(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you knocked unconscious? \_\_\_Yes \_\_\_No In a daze? \_\_\_Yes \_\_\_No**

**Did you go to the hospital? \_\_\_Yes \_\_\_No If yes, when? \_\_\_At time of accident \_\_\_Next day**

**How did you get to the hospital? \_\_\_Ambulance \_\_\_Own transportation**

**Name of hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attended by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you x-rayed at the hospital?\_\_Yes \_\_No If so, what was the diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you admitted to the hospital? \_\_\_Yes \_\_\_No How long did you stay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was any other doctor consulted after your accident? \_\_\_Yes \_\_\_No**

**If yes, Dr’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What treatment was given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often did you see the doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long did you see the doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any complaints in the involved area before? \_\_\_Yes \_\_\_No**

**If so, give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your pain constant? \_\_\_Yes \_\_\_No Is the pain on and off? \_\_\_Yes \_\_\_No**

**Sharp? \_\_Yes \_\_\_No Dull? \_\_\_Yes \_\_\_No**

**Did you have numbness or tingling in your arm? \_\_\_Yes \_\_\_No In your hands? \_\_\_Yes \_\_\_No**

**In your fingers? \_\_\_Yes \_\_\_No In your legs? \_\_\_Yes \_\_\_No In your feet? \_\_\_Yes \_\_\_No**

**Do your knees ache \_\_Yes \_\_No Do you have cramps in your legs?\_\_Yes \_\_No**

**In your arms? \_\_Yes \_\_No**

**Do any of the following relieve your pain? \_\_Heating pad \_\_Hot bath \_\_Shower \_\_Ice pack \_\_Rest \_\_Medication**

**What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you lost time at work because of the accident? \_\_\_Yes \_\_\_No**

**If yes, give dates lost: from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you required to lift over 10 lbs.? \_\_\_Yes \_\_\_No**

**Before the injury were you capable of working on an equal basis with others your age? \_\_\_Yes \_\_\_No**

**Totally disabled from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Partially disabled from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**