

**Renaissance Chiropractic Center**

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**Automobile Collision Questionnaire**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of accident: \_\_\_\_\_

**PLEASE WRITE A DESCRIPTION OF THE ACCIDENT:**

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

If auto accident, were you:  driver  passenger  pedestrian

Location: City \_\_\_\_\_ State \_\_\_\_\_ Street(s) \_\_\_\_\_

Road Conditions:  [Dry]  [Wet]  [Icy] Other: \_\_\_\_\_

**What kind of vehicle were you in:** \_\_\_\_\_

What type of transmission in your vehicle:  Automatic  Manual (stick-shift)

Were you aware of the impending collision or were you surprised?  Aware  Surprised

If auto collision, were you struck from:  behind  right side  left side  front

Did the other car strike yours?  yes  no Did your car strike the others involved?  yes  no

Was your foot on the brake?  yes  no were you wearing your seatbelt?  yes  no

Did any Airbags deploy?  yes  no  front  side curtain

At the impact was your head facing:  forward  to the right  to the left  Other: \_\_\_\_\_

How was the headrest positioned for your head?  high  low  middle  no head rest

After the collision, what direction was your vehicle facing:  Same  to the right  to the left

facing the opposite direction  not sure  Other: \_\_\_\_\_

Were there multiple impacts:  yes  no

**What was the other vehicle?** \_\_\_\_\_

Were there other vehicles involved:  yes  no how many? \_\_\_\_\_

What kind: \_\_\_\_\_

Did the impact cause you to lose your glasses or hat?  yes  no

Did you hit any part of the body on anything inside the vehicle?  no  yes, what? \_\_\_\_\_

Did you lose consciousness?  yes  no Were you treated by the Paramedics at the scene?  yes  no

Were you taken by ambulance to the hospital emergency room?  yes  no

Did you have x-rays taken?  yes  no what regions? \_\_\_\_\_

Were you given any medications?  yes  no what? \_\_\_\_\_

Condition Since Accident:  [Worsened]  [Improved]  [Stayed the same]

**PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ringing       | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed       | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Smell      | <input type="checkbox"/> _____         |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Depression               | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> _____         |

**ALL INSURANCE INFORMATION NEEDS TO BE COMPLETED**

**Patient's Auto Insurance Company**

Do you have Personal Injury Protection (PIP)  Yes  No

Company Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Claim Manager's name: \_\_\_\_\_

**Auto Insurance Company Responsible in Accident:**

Company Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Name of person responsible for accident: \_\_\_\_\_

Name of insured on this policy: \_\_\_\_\_

Claim #: \_\_\_\_\_ Claim Manager's name: \_\_\_\_\_

**Do you have an attorney involved in this case?**  Yes  No

If so, attorney's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Parent/Guardian's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_