NeuroTarget Chiropractic

12358 River Ridge Blvd.
Burnsville, MN 55337
p(952) 681-7746
f(952) 681-7654
John R. Pietila, DC, DACNB
Jennifer L. Engesether, DC, DACNB

Motor Vehicle Accident Questionnaire

Name:_________________________________ DOB:_____________________ Date:___________________
Date of Injury:___________________________ Time:___________________ a.m., p.m.

Approximate Location (City, State, Crossroads):____

Were you? __Driver __Passenger __Front Seat __Back Seat __Pedestrian __Bicyclist

__Head on collision __LT __RT
__Rear-end collision __LT __RT
__Broadside collision __From LT __From RT
__Car hit dip in road, no collision
__Patient's car rear-end in front
__Other:____

Patient's head data: __ Head hit rear head rest __Head hit by flying object __Head hit
__Windshield __Steering Wheel __Roof __Other:_______________________________

Patient Detail at Time of Crash Impact: __Airbag Transmission: __ Manual
__Seat belts fastened __Braking __ Automatic
__Shoulder belts fastened __Bracing for impact
__Head position: __LT __RT __Straight __Turned around
__Hand position: __One on wheel __Two on wheel
__Sitting position: __Knees LT __Knees RT __Knees straight
__Other injuries: __Knee __Leg __Ankle __Foot __Hip __Jaw
__Shoulder __Elbow __Wrist __Hand __Bruises __Contusions

Were you caught by surprise relative to the impact collision: __Yes __No
Felt body go: __Fwd then back __Back then Fwd
Did your body strike anything else in the car? __Yes __No If yes:____
Did your vehicle strike other vehicle? __Yes __No
Was your car struck by another car after the first impact? __Yes __No
Wearing glasses? __Yes __No Still on? __Yes __No Bent/Broken __Yes __No End up where_____________

Est. property damage?_____________ __Totaled __Drivable __Not drivable
Mirrors broken/bent? __Yes __No Seat broken/bent? __Yes __No
Police on scene? __Yes __No Report made? __Yes __No
Were you knock unconscious? __Yes __No If so, how long?______________________
Initial Symptoms: __Headache __Dizzy __Disoriented __Shock __Neck pain/stiff __Jaw pain
__Back pain/stiff __Numbness/Tingling
First symptoms appeared:______________hrs./mins. After the accident
After Accident: __Went home __Taken to the hospital by________________________
__Went to doctor's office __Went to hospital later(date and time)__________________________
__Other:____
At Hospital/Doctors what was performed: __X-rays __Labs __Meds __Collar __Other:__________________________
__Follow-up instructions____ __None
Was another doctor consulted after the accident: __Yes __No If so, Doctor's name:_____________________________
Have you lost time from work because of the injury? __Yes __No Date?____________________________
Did you return to work? __Yes __No If not, date returned to work?______________________________________
Are your work activities restricted as a result of the accident? __Yes __No

Name:_________________________________DOB:_______________

Your Auto Insurance Company:
Name:____ Phone:________________________________

Address:____ Policy and/or Claim #__________________________

Other people in the car? __Yes __No
Name and phone number:____
Name and phone number:____
Name and phone number:____

Date:______________________ ____
Patient Signature

Date:______________________ ____
Parent or Guardian (if minor)

Office Use Only: