BERTELSMAN CHIROPRACTIC
AUTO ACCIDENT QUESTIONNAIRE

Date _____ Date of Accident_____

Name _____ Age _____ Gender M F

Brief description of accident (i.e. rear-ended, head on, side impact, etc.) _____

_____

_____

Describe any secondary collisions (i.e. pushed into vehicle in front of you) _____

_____

Do you recall striking anything inside the vehicle? (i.e. knees on dashboard, head on windshield) ☐ No ☐ Yes_____

_____

What type of vehicle were you in? _____ Estimated Speed _____

What type of vehicle was the other driver in? _____ Estimated Speed _____

Describe damage to your vehicle ☐ Light ☐ Moderate ☐ Heavy Damage Estimate $_____

After the accident was your vehicle ☐ Drivable ☐ Not drivable

Were you ☐ Driver ☐ Passenger - Sitting: _____

At time of the accident:
Visibility Was ☐ Good ☐ Poor
Time of Day ☐ Daylight ☐ Night

Road conditions ☐ Dry ☐ Wet ☐ Snow / Ice

At the time of impact:
Were you looking ☐ Toward Left ☐ Straight Ahead ☐ Toward Right
☐ Up ☐ Down

Was your foot on the brake? ☐ Yes ☐ No

Were you ☐ Braced for Impact ☐ Unaware of Impending Collision

Were you wearing a seatbelt? ☐ Yes ☐ No Did your airbag deploy? ☐ Yes ☐ No

Was your headrest ☐ Adjusted Properly ☐ Not Adjusted ☐ Don't Recall

Stop Here. Lower section for doctor's evaluation

☐ MIC 1	Subjective Symptoms	10 pts.
☐ MIC 2	Symptoms, Loss of ROM	50 pts.
☐ MIC 3	Symptoms, ROM & Neuro	90 pts.

10 - 30	Excellent
35 - 70	Good
75 - 100	Poor
105 - 125	Guarded
130 - 165	Unstable

Modifiers

☐ Canal Size	10 - 12mm	20
☐ Canal Size	13 - 15`mm	15
☐ Kyphotic Cervical Curve		15
☐ Straightened Cervical Curve		10
☐ Blocked/Fused Segments		15
☐ Loss of Consciousness		15
☐ Pre-existing DJD		10

☐ Hyper/Hypo Mobility on Flex./Ext.

Complicating Health/Lifestyle Factors:

_____

_____

_____

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