Natural Wonders Healthcare
Dr. Atil Narayan, DACM, L.Ac • Phone: (626) 377- 0753 • Fax: (626) 465-4694

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because your answers will help us determine if acupuncture can help you. If we do not sincerely believe your condition will response satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as accurate as possible while completing this form. Thank you.

Name: _____ Today's Date: _____

Please explain in detail how your accident happened
_____
_____
_____
_____
_____
_____

Date of Accident: _____ Time: _____ ☐am ☐pm Location: _____

Were you the: ☐ ☐Driver ☐ ☐Pedestrian ☐ ☐Front Passenger ☐ ☐Rear Passenger ☐ ☐Other _____
Were you wearing your seat belt? ☐ ☐Yes ☐☐ No
Was the vehicle equipped with airbags? ☐ ☐Yes ☐☐ No If yes, did they inflate? ☐ ☐Yes ☐ ☐No
Make and Model of vehicle you were occupying: _____
What did your vehicle impact? ☐☐ Another vehicle/make and model: _____
☐ Other: _____
Did any part of your body strike anything in the vehicle? ☐ ☐Yes ☐☐ No If yes, please describe: _____
_____
In which direction were you heading? ☐☐ N ☐☐ S ☐☐ E ☐ ☐W
What was the approximate speed of your vehicle? _____m.p.h.
Other driver, if applicable, was heading ☐ ☐N ☐ ☐S ☐☐ E ☐☐ W
Approximate speed of other driver: _____m.p.h.
Did the impact to your vehicle come from the: ☐☐ Front ☐ ☐Rear ☐ ☐Right Side ☐ ☐Left Side ☐☐ Other: _____
During impact, were you facing: ☐ ☐Right ☐☐ Left ☐ ☐Forward

Describe how you felt immediately after the accident: _____
_____
_____

Were you knocked unconscious? ☐☐ No ☐☐ Yes If yes, how long? _____
Did you go to a hospital/emergency center? ☐☐ No ☐ ☐Yes If yes, where and when? _____
_____
Describe any treatment you received: _____
Were x-rays taken? ☐ ☐Yes ☐☐ No Was medication prescribed? ☐☐ Yes, type :_____ ☐☐ No
Have you seen any other doctor for this accident? ☐☐ Yes☐ ☐No
If so, what was the doctor's name? _____ ☐D.C. ☐M.D. ☐D.O. ☐D.D.S. ☐Other
What treatment or recommendations were given? _____
How often did you see the doctor? How long did you see the doctor? _____

Check symptoms you have noticed since the accident:

☐☐ Headache	☐ ☐Dizziness	☐ ☐Nausea	☐ ☐Tingling in Arms
☐☐ Memory Loss	☐ ☐Loss of Balance	☐ ☐Fever	☐ ☐ Numbness in Fingers
☐☐ Blurred Vision	☐ ☐Light Bothers Eyes	☐ ☐Hands Cold	☐ ☐Upper Back Pain
☐☐ Buzzing in Ears	☐ ☐Head Seems Too Heavy	☐ ☐Feet Cold	☐ ☐Upper Back Stiffness
☐☐ Ears Ringing	☐ ☐Loss of Smell	☐ ☐Jaw Problems	☐ ☐Low Back Pain
☐☐Fainting	☐ ☐Loss of Taste	☐ ☐Neck Pain	☐ ☐Leg Pain
☐☐ Face Flushed	☐ ☐Shortness of Breath	☐ ☐Neck Stiffness	☐ ☐Tingling in Legs
☐☐ Nervousness	☐ ☐ Chest Pain	☐ ☐Arm/Shoulder Pain	☐ ☐Numbness in Toes

Have you ever had any complaints in the involved area(s) before? □ ☐Yes □☐ No

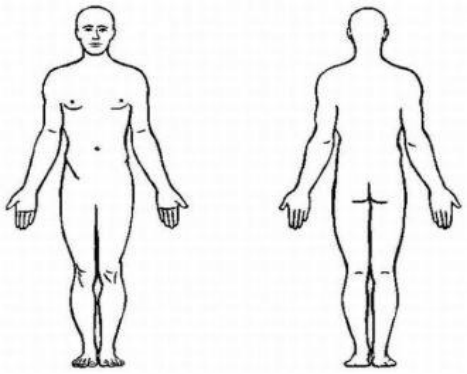
Are your work/school activities restricted as a result of this accident? □ ☐Yes □ ☐No

Since this injury are your symptoms: □☐ improving □ ☐getting worse □☐ constant □☐ same □☐ comes and goes

List major complaints and rate the intensity of the pain on a scale of 1 to 10.

1. Primary complaint: _____ 1 2 3 4 5 6 7 8 9 10
2. Secondary complaint: _____ 1 2 3 4 5 6 7 8 9 10
3. Other complaint: _____ 1 2 3 4 5 6 7 8 9 10

Please mark on the drawings below the area(s) and type of pain/sensation that you are feeling.



Numbness……..N
Pain…….P
Tingling……...T
Ache……A
Stiffness……..S

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date