Jade Acupuncture

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Automobile Accident Injury Questionnaire

Insurance/Account Information

Patient Name (*Please Print*):____

Insurance Companies involved:

My Company:______________________________ Policy #: ______________________

Responsible Party's Ins:_______________________ Policy #: ______________________

Claim #:_____________________________

Send Claims To:

Claim Manger (PIP)/Contact Person:____

Phone: _____________________________ Fax: ______________________________

Mailing Address:____
Street/PO Box

__________________________________ __________ ____________________________
City State Zip Code

Explanation of Accident: Date of the Accident: _________ Time:___________

Location:____

How did the accident occur?

____

____

Did you report the Accident? ___________ If so, to whom? _________________________

Were you the (*circle one*): The Driver A Passenger A Pedestrian Cyclist

Were you struck from (*circle one*): Behind The Right The Left The Front

As a result of the accident were citations issued to (*circle one*):

You/The driver of your car The other driver None

History of Injury - List the extent of your injuries as you know them:

____

____

Did you notice your symptoms immediately? If no, when did you fist notice them?

____

____

Did you go to the hospital following the accident? _______________

Circle any symptoms you have noticed since the accident:

Headaches	Nervousness	Stomach Upset	Fatigue
Neck Pain	Tension	Dizziness	Depression
Neck Stiffness	Irritability	Head Feel Heavy	Diarrhea/Constipation
Difficulty Sleeping	Chest Pain	Pins & Needles in arms & legs	Shortness of Breath
Back Pain	Cold Sweats	Numbness in Fingers/ Toes	Fever

Patient Signiture:____ Date: _______________