

Auto Accident Questionnaire

KOSA Acupuncture
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Name: _____ DOB: _____

Gender: F M

Address: _____

Phone number: _____

Emergency contact: Name: _____

Phone number: _____ Relationship: _____

Auto Insurance Company

Name: _____

Address: _____

Phone number: _____

Auto insurance claim # and/or policy number: _____

Adjuster's name: _____

Note to the patient:

Please inform your auto insurance company that you are currently receiving treatments from this clinic.

DOL (Date of loss) when:

Whose fault? _____

Belted driver? Yes No

Are there passengers? Yes No If Yes, how many? _____

What time and date? _____

What happened?

Approximate speed: (you and/or other party):

Did you go to the E.R? Yes No

If yes, what test were performed? (MRI, x-ray etc.) _____

Immediately following the accident how did you feel? (dizziness, headache, neck pain and etc..)

After one day or several days, how do you feel? (worse, better, and where specifically?)

As of right now, list all your pains or symptoms due to the accident:

1) _____

Intensity of symptom: Mild Moderate Severe

Duration of symptom: Constant Sometimes Frequency _____

2) _____

Intensity of symptom: Mild Moderate Severe

Duration of symptom: Constant Sometimes Frequency _____

3) _____

Intensity of symptom: Mild Moderate Severe

Duration of symptom: Constant Sometimes Frequency _____

4) _____

Intensity of symptom: Mild Moderate Severe

Duration of symptom: Constant Sometimes Frequency _____

List any other current complaints due to the accident:

Have you received other treatments for this accident? Yes No

If so, please list:

Were the treatments effective?

For Acupuncturist only

Objective:

ROM (Range of motion) of the _____

Flexion: _____

Extension: _____

Left turn: _____

Right turn: _____

Upon palpation of _____

Pt rated the pain a ___/10

ROM (Range of motion) of the _____

Flexion: _____

Extension: _____

Left turn: _____

Right turn: _____

Upon palpation of _____

Pt rated the pain a ___/10

Treatment goal:

Treatment plan:

Patient needs to come to clinic _____ x /week

Patient will receive:

Patient office visit: 10 min 20 min 30 min 45 min 1 hr

Acupuncture: 15 min 30 min 45 min >45 min

Manual Therapy: (Guasha, Tuina) 15 min 30 min

Suction or Compression (Moxa & Cupping): 15 min 30 min

Massage: 15 min 30 min

Infrared Heat: 15 min 30 min

Application of Hot or Cold Packs: 15 min 30 min

Special Instructions:
