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.

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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

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Flexion: _____
Extension: _____
Left turn: _____
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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:

_____

_____

_____