



# Bowman Chiropractic

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## Automobile Accident Questionnaire 2

Name: \_\_\_\_\_

Did you have any physical complaints before the accident? YES NO

If yes, please describe in detail \_\_\_\_\_

Please describe how you felt: During the accident \_\_\_\_\_

Immediately after: \_\_\_\_\_ Later that day \_\_\_\_\_

The next day \_\_\_\_\_

What are your present complaints & symptoms?

\_\_\_\_\_

Did you have any congenital (from birth) factors, which relate to this problem? YES NO

If yes, please describe

Did you have any previous illness which relate to this case? YES NO

If yes, please describe

### PLEASE CIRCLE:

Since the accident occurred, are your symptoms:

Improving                      Getting Worse                      Same

### Symptoms you have noticed since the accident:

- Headache      Irritability      Numbness in Toes      Face Flushed      Feet Cold      Neck Pain      Chest Pain
- Shortness of Breath      Buzzing in Ears      Hands Cold      Neck Stiff      Dizziness      Fatigue      Loss of Balance      Stomach Upset
- Sleeping Problems      Depression      Head Seems too Heavy      Fainting      Constipation      Back Pain      Pins & Needles in Legs
- Tension      Diarrhea      Numbness in Fingers      Pins & Needles in Arms      Loss of Smell      Nervousness      Light bothers Eyes      Ear Ringing
- Fever      Cold Sweat      Loss of Appetite      Increased Appetite

Did you notice any activity restrictions as a result of this injury? YES NO

If yes, please describe

\_\_\_\_\_

### PLEASE READ

Please note: You may be responsible for your deductible under No-Fault. This sheet is for your protection in the event a court hearing is necessary. In the event I fail to prosecute the claim under No-Fault for this condition, or it is determined that there is no case, I \_\_\_\_\_ hereby agree to pay the doctors of Bowman Chiropractic their usual fees

(Full name)

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_