

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ PHONE: (____) _____

ADDRESS: _____ CITY/STATE/ZIP: _____

AGE: _____ BIRTHDATE: _____ SEX: _____ SS # _____

EMPLOYER'S NAME/ADDRESS: _____

YOUR INSURANCE CO: _____ POLICY #: _____

AGENT'S NAME & PHONE: _____

NAME ON POLICY (IF OTHER THAN SELF): _____

RESPONSIBLE PARTY'S NAME/ADDRESS: _____

POLICY HOLDER'S NAME & POLICY #: _____

ATTORNEY:

NAME: _____ PHONE: (____) _____

Address _____ CITY/STATE/ZIP: _____

Were there any witnesses? () Yes () No Witness(es) Names: _____

NATURE OF ACCIDENT: () AUTO () Work Related () OTHER _____

**** If Auto, please bring in a copy of the accident report****

1. Date of Accident: _____ Time of Day: _____
2. Were you: () Driver? () Passenger? () Front Seat? () Back Seat?
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed: () N () E () S () W
on (name of street) _____
5. What direction was other vehicle headed? () N () E () S () W
on (name of street) _____
6. Were you struck from: () Behind () Front () Left Side () Right Side
7. Approximate speed of your car: _____ mph Other car's speed: _____ mph
8. Were you knocked unconscious? () Yes () No If yes, how long? _____
9. Were police notified? () Yes () No
10. In your own words, please describe accident: _____

11. Did you have any physical complaints BEFORE the accident? () Yes () No
If yes, please describe in detail: _____

12. Please describe how you felt:
 - A. DURING the accident: _____
 - B. IMMEDIATELY AFTER the accident: _____
 - C. LATER THAT DAY: _____
 - D. THE NEXT DAY: _____

13. Are you pregnant? () Yes () No

14. Have you ever been to a Chiropractor? () Yes () No

15. What are your PRESENT complains and symptoms? _____

16. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No
If yes, please describe: _____

17. Do you have any previous illnesses which relate to this case? () Yes () No
If yes, please describe: _____

18. Have you ever been involved in an auto accident before? () Yes () No
If yes, please describe and give dates and types of accidents and injuries: _____

19. Were you given Emergency Medical care at the accident site? () Yes () No

20. Did you go to the hospital? () Yes () No

Hospital Details _____

21. Have you been treated by another doctor since the accident? () Yes () No
If yes, please give doctor's name/address/phone: _____

What type of treatment did you receive? _____

22. Since this injury occurred, are your symptoms:
() Improving () Getting Worse () Same

23. Circle the symptoms you have noticed SINCE the accident:

Headache	Irritability	Face Flushed	Cold Feet	Cold hands	Neck pain
Chest Pain	Buzzing in ears	Stomach upset	Constipation	Loss of Smell	Loss of Balance
Diarrhea	Dizziness	Fatigue	Fever	Loss of Taste	Cold Sweats
Back Pain	Nervousness	Fainting	Depression	Memory Loss	ringing in Ears
Tension	Sleeping problems	Lights bother eyes	Numbness in fingers	Numbness in toes	
Pins/Needles in legs	Pins/Needles in arms	Shortness of Breath	Head seems heavy		
Loss of Taste	Other _____				

24. Have you lost time from work as a result of this accident? () Yes () No
If yes, please complete the following:

- A. Last day worked? _____
- B. Type of employment _____
- C. Present Salary: _____
- D. Are you being compensated for lost work time? () Yes () No If Yes, what? _____

25. Do you notice any activity restrictions as a result of this injury? () Yes () No
If yes, please describe in detail: _____

26. Please describe any other pertinent information: _____

Printed Name Patient Signature Date