PERSONAL INJURY QUESTIONNAIRE

Name____DOB____________________________

Address____Phone (____) ____________________

City____State____________Zip____________________________

Email____Occupation_______________________________________

Insurance Information

Please note YOU must contact the responsible insurance company **prior** to treatment to report a claim

YOUR Auto Insurance____Policy#____________________________
Address/contact info: ____ Claim #____________________________
Do you have Medpay on your policy? Y / N

Responsible party's auto insurance __________________________________ Policy#__________________________
Address/contact info: ____Claim #___________________________

Attorney Information (if retained)

Attorney____Phone (_____) _____________________

Address____City______________State________Zip_________

ACCIDENT INFORMATION

(please provide a copy of the accident report)

NATURE OF ACCIDENT
(please circle the appropriate responses where applicable)

1. Date of accident__________________________________ Time of day__________________________________
2. Were you the: Driver Passenger / Front seat Back seat
3. Number of people in your vehicle________________________ Were you wearing a seat belt? ______________
4. What direction were you headed? North South East West
5. What direction was OTHER vehicle headed? North South East West
6. Were you struck from: Behind Front Left side Right side
7. Approximate speed of your car? ________mph Other car ______mph
8. Were you knocked unconscious? YES/NO If yes, for how long? _______________________________
9. Were police notified? YES/ NO If yes, was a citation issued? ___________________________________
10. Were there any witnesses? YES/ NO Name(s)____
11. Did you report injuries at the scene? Y / N If so, what type of injuries were sustained?
    ____
12. Did you go to the Emergency Room after the accident? Y /N If yes, were you transported via ambulance? Y /N
13. In your own words, please describe the accident:
    ____
    ____
    ____
14. Did you have any physical complaints **BEFORE** the accident? YES/NO IF YES, please describe in detail:
    ____
    ____
    ____

15. Please describe how you felt:
    - DURING the accident ____
    - IMMEDIATELY AFTER the accident___________________________________
    - LATER THAT DAY____
    - THE NEXT DAY____
16. What are your **PRESENT**complaints and symptoms?

    ____

    ____
17. Do you have any congenital (from birth) factors which relate to this problem? YES/NO If YES, please describe:

    ____

    ____
18. Do you have any previous illnesses which relate to this case? YES / NO If YES, please describe:

    ____

    ____
19. Have you ever been involved in an accident before? YES/ NO If YES, please describe, including date(s) and type(s) of accidents as well as injuries received:

    ____

    ____

    ____
20. Have you been treated by another doctor since the accident? YES / NO If YES, please list doctor(s) name:

    ____
21. Do you plan to seek other medical treatment in addition to chiropractic for your injuries? Y / N If yes, please provide doctor's name(s)____
22. Since the injury occurred, are your symptoms: Improving Getting Worse Same
23. CHECK SYMPTOMS YOU HAVE NOTCIED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Face flushed
☐ Neck Pain	☐ Chest Pain	☐ Shortness of breath	☐ Buzzing in ears
☐ Stick neck	☐ Dizziness	☐ Fatigue	☐ Loss of balance
☐ Sleeping problems	☐ Head seems heavy	☐ Depression	☐ Fainting
☐ Back pain	☐ Pins & needles in arm	☐ Light sensitivity	☐ Loss of smell
☐ Nervousness	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste
☐ Tension	☐ Numbness in fingers	☐ Ringing in ears	☐ Feet cold
☐ Diarrhea	☐ Stomach upset	☐ Constipation	☐ Hands cold

Symptoms other than the above____

24. Have you lost time from work because of this accident? YES/ NO If yes, please complete this question:
    a) Last day worked ____
    b) Type of employment____
25. Do you notice any activity restrictions as a result of this injury? YES / NO If YES, please describe in detail:

    ____

    ____

    ____
26. Other pertinent information:

    ____

    ____

    ____

______________________________/____

Date Patient Signature