PERSONAL INJURY QUESTIONAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS…THANK YOU!)

NAME:____ DATE:__________________________________

1. Describe your current complaint that you are requesting evaluation and treatment for from this office. Please check the symptoms that you have since the accident: ____
____

☐ Headaches	☐ Numbness in feet	☐ Numbness in toes	☐ Loss of Memory
☐ Neck Pain/Stiffness	☐ Arm/ Leg Weakness	☐ Dizziness	☐ Clicking/Popping Jaw
☐ Mid Back Pain	☐ Sleeping Problems	☐ Numbness in fingers	☐ Facial Pain
☐ Low Back Pain	☐ Eyes Light Sensitive	☐ Fainting	☐ Irritability
☐ Arm Pain	☐ Fatigue	☐ Breath Shortness	☐ Loss of Balance
☐ Leg Pain	☐ Depression	☐ Ringing/Buzzing	☐ Cold Feet
☐ Muscle Spasm/Cramping	☐ Cold hands	☐ Chest Pain	☐ Pain Behind Eyes
☐ Pain across Shoulder Blades	☐ Diarrhea	☐ Constipation	

2. What was the Date of the Accident?__________ Time: ____________ AM/PM
3. Since the accident, are conditions becoming: ☐ BETTER ☐ WORSE ☐ SAME
4. Describe your symptoms: ☐ CONSTANT ☐ COMES & GOES
5. What do you believe is the cause of your current symptoms?
____
6. What relieves your symptoms? ____
7. What aggravates your symptoms? ____
8. What prior treatment have you had for the symptoms checked above? (include Dr.'s Name/ Location, date seen, treatment, results)
____
____
9. Who is your family physician for regular check-ups? ____
   Date last seen? ______________________ What treatment? ____
10. Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes explain: ________________________
____
11. Have you ever had any prior automobile accidents or ever had any serious falls/injuries? If yes, please describe in detail below:
____
12. What Medications are you currently taking? ____
   Taken in last 6 months? ____
13. Have you ever had any surgeries or been hospitalized overnight? If yes, please give details: ______________________________
____
14. Are you currently under the care of any other doctors for any Health related concerns? If yes, please describe. ___________________
____
15. Have you ever seen a Chiropractor before? If yes, then who, where & what treated for? _________________________________
16. Family History: Place a (X) if any family member has suffered from:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Allergy	☐ Arthritis
☐ High Blood Pressure	☐ Cancer	☐ Migraines
☐ Heart Attacks	☐ Other, list: ___________________________	

17. Who was the driver of your car? ____
18. Where were you seated in the car? ____
19. Who owns the car you were in? Year & Model of your ar?____
   Year & Model of the other car? ____
20. What was the approximate damage done to your car? ____
21. Visibility at the time of the accident? ☐ poor ☐ fair ☐ good ☐ other: _________________________________
22. Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other (describe): ______________
23. Where was your car struck? ____
24. Please describe the accident in your own words:____
____

25. Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact ☐ Rear-end car in front of you
☐ Rear impact ☐ Non-collision

26. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:_________________________

28. Did you see the accident coming? ☐ Yes ☐ No

29. Did you brace yourself for impact? ☐ Yes ☐ No

30. Were you wearing your seat belt? ☐ Yes ☐ No

30a. Did your airbag deploy? ? ☐ Yes ☐ No

31. Were you wearing your shoulder harness? ☐ Yes ☐ No

32. Does your car have headrests? ☐ Yes ☐ No

If yes, what was the position of your headrest compared to your head before the accident?
☐ Top of headrest even with **bottom** of head.
☐ Top of headrest even with **top** of head.
☐ Top of headrest even with **middle** of neck

33. Was your car moving at the time of the accident? ☐ Yes ☐ No

If yes, how fast would you estimate you were going? ________ mph

34. How fast do you estimate the other car was going? ____________ mph

35. Head/Body position at time of impact:
☐ Head turned left/right ☐ Body straight in sitting position
☐ Head looking back ☐ Body rotated right/left
☐ Head straight forward ☐ Other: ___________________

36. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _______________

37. Were you wearing a hat or glasses? ☐ Yes ☐ No

If yes, where were they located after the accident? ____

38. Could you move all parts of your body after the accident? ☐ Yes ☐ No

If no, what parts couldn't you move and why? ____

39. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

If no, why not? ____

40. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? ____

41. Did you get any bruises? ☐ Yes ☐ No If yes, where? ____

42. Please describe what symptoms you felt:
Immediately after the accident: ____
Later that day: ____
The next day: ____

43. Have you missed time from work? ☐ Yes ☐ No

If yes, full time off work: __________________ to _________________________
If yes, part -time off work: ___________________ to _________________________

44. Did you seek medical help immediately after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Drove own car ☐ Someone else drove me. ☐ Other: _______________

45. Who was the 1st Doctor that treated you?
Name: ____
Date seen: ____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No Were you: ☐ Sitting or ☐ Standing
Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive? ____
What benefits did you receive from the treatment? ____

46. Are you pregnant? ☐ Yes ☐ No ☐ Not sure

47. Do you have an attorney representing you for this claim? ☐ Yes ☐ No

If yes, who? ____

SIGNATURE OF PATIENT: ____DATE: ______________________