living well
CHIROPRACTIC
A FAMILY WELLNESS CENTER

Personal Injury Questionnaire

Name _____ Social Security Number _____
Date of Birth _____ Home Number _____ Mobile _____
Address _____ City _____State _____ Zip _____
Employer's Name _____ Employer's Address _____
Your Insurance Company _____ Policy number _____
Agent's Name _____ Agent's Phone Number _____
Claim Number _____ Claim Adjuster's Name_____
Claim Adjuster's Phone Number _____
Address to send claims_____
Have you retained an attorney? ( ) Yes ( ) No Name _____
Phone number_____
Attorney's address_____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Other vehicle? _____
4. Type of vehicle you were driving? _____year_____make_____model
5. Nearest intersection to the accident _____
6. What Direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
7. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
8. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you rendered unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were the police notified? ( ) Yes ( ) No! If so, were any citations issued and to whom?
   _____
10. In your own words, please describe the 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. What are your PRESENT complaints and symptoms? _____
_____
_____

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

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

16. Have you ever been involved in an accident before: ( ) No ( ) Yes If yes, please describe, including date(s) and Type(s) of accident(s), doctor(s) you treated with, as well as injury(s) received.

_____
_____

17. Where were you taken after the accident:_____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list the doctor's name and address:_____
_____
What type of treatment did you receive?_____
_____

19. Since this injury occurred, are your symptoms: ( ) Improving ( )Getting worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Cold Feet
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Cold Hands
Neck Stiffness	Dizziness	Fatigue	Loss of Balance	Upset Stomach
Sleeping problems	Head seems heavy	Depression	Fainting	Constipation
Back problems	Pins & needles in arms	Light bother eyes	Loss of smell	Cold Sweats
Nervousness	Pins & needles in legs	Loss of memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ringing in Ears	Diarrhea	_____

Symptoms Other Than Above _____ What makes symptoms better or worse?
_____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete the following questions:
a. Last day worked:_____
b. Type of Employment:_____
c. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:_____
_____

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

23. Other pertinent information:_____
_____

24. Make/Model of your vehicle _____
Make/Model of their vehicle _____
Did you have your foot on the gas or brake pedal? _____

_____ _____
Date Patient's Signature