

Personal Injury Questionnaire

Name _____ Cell Phone () _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Sex _____ Alternate Number () _____

ATTORNEY or ADVOCATE INFORMATION if applicable

Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____

NATURE OF ACCIDENT

1. Date of Accident _____ Time of Day _____ Weather Conditions _____
2. Were you: () Driver or Passenger in the () Front Seat () Back Seat
3. Do you have head rests? () No () Yes Were you wearing a seat belt? () No () Yes
4. What direction were you headed? () North () South () East () West on (name of street) _____
Cross Street if applicable? _____ In what City/State? _____
5. What direction was the other vehicle headed? () North () South () East () West on (name of street) _____

6. From which direction were you struck? () Behind () Front () Left side () Right side
7. Approximate speed of your car was _____ mph; And the other car _____ mph.
8. Were you knocked unconscious? () No () Yes (If yes, for how long): _____
9. Were police notified? () No () Yes If yes, was a report taken? () No () Yes
10. In your own words, please describe the accident. _____

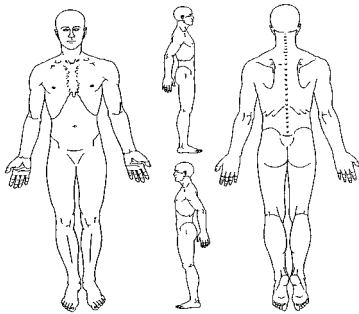
11. How much damage was estimated to YOUR vehicle? \$ _____ (leave blank if you have NOT had it estimated as of this date.)
12. Did you take pictures of your automobile? () No () Yes If NO then you MUST take pictures before the vehicle is repaired.
13. Did you have any physical complaints BEFORE THE ACCIDENT? () No () Yes (If yes, please describe in detail): _____

14. Please describe how you felt emotionally and physically (did symptoms get worse?):
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____
15. Have you been treated by another doctor, other than this chiropractic office, since this accident?
() No () Yes (If yes, Dr.'s name & address): _____
What type of treatment did you receive? _____
16. Since this injury occurred, are your overall symptoms: () Improving () Getting Worse () Staying the Same

17. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|---|---|--|--|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Head feels Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arm Pain |
- Symptoms other than above _____

18. **Mark an X on the picture where you have pain or discomfort. If multiple areas are injured please number them and answer the questions below.**



Area #1: What aggravates or makes the condition worse? _____

What relieves or makes the condition better? _____

Type of pain or discomfort: Sharp Dull Ache Numb/Tingling Burning

Throbbing Other _____

Overall Frequency of complaint: Constant 100% of the time Frequent 75%

Intermittent-50% Occasional-25%

Circle the severity of your pain at its BEST & at its WORST.

Use the scale of Zero (no pain) to 10 (severe pain).

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Area #2: What aggravates or makes the condition worse? _____

What relieves or makes the condition better? _____

Type of pain or discomfort: Sharp Dull Ache Numb/Tingling Burning Throbbing Other _____

Overall Frequency of complaint: Constant 100% of the time Frequent 75% Intermittent-50% Occasional-25%

Circle the severity of your pain at its BEST & at its WORST.

Use the scale of Zero (no pain) to 10 (severe pain).

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Area #3: What aggravates or makes the condition worse? _____

What relieves or makes the condition better? _____

Type of pain or discomfort: Sharp Dull Ache Numb/Tingling Burning Throbbing Other _____

Overall Frequency of complaint: Constant 100% of the time Frequent 75% Intermittent-50% Occasional-25%

Circle the severity of your pain at its BEST & at its WORST.

Use the scale of Zero (no pain) to 10 (severe pain).

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

19. Have you lost time from work as a result of this accident? () No () Yes What Dates? _____

20. Have you ever been involved in an accident before: () No () Yes (If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received): _____

PATIENT'S SIGNATURE

Date