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 <u>your</u> 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 <u>If NO then you MUST take pictures before the vehicle is repaired.</u>
13. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) No ( ) Yes (If yes, please describe in detail): _____

_____

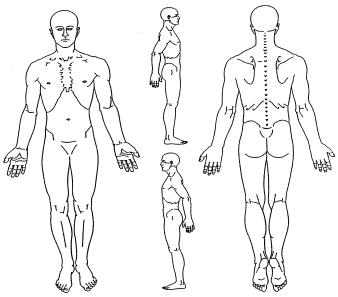
14. Please describe how you felt emotionally and physically (did symptoms get worse?):
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
15. Have you been treated by another doctor, other than this chiropractic office, 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:

( )Headache	( )Irritability	( )Numbness in Toes	( )Face Flushed	( )Feet Cold
( )Neck Pain	( )Chest Pain	( )Shortness of Breath	( )Buzzing in Ears	( )Hands Cold
( )Neck Stiff	( )Dizziness	( )Fatigue	( )Loss of Balance	( )Ears Ring
( )Sleep Problems	( )Head feels Heavy	( )Depression	( )Fainting	( )Constipation
( )Back Pain	( )Pins & Needles in Arms	( )Lights Bother Eyes	( )Loss of Smell	( )Cold Sweats
( )Nervousness	( )Pins & Needles in Legs	( )Loss of Memory	( )Loss of Taste	( )Fever
( )Tension	( )Numbness in Fingers	( )Upset Stomach	( )Diarrhea	( )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).

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 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).

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 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).

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 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 Name (Print Please): _____ Date of Birth: ____/____/____

Patient Signature: _____ Date of Signature: ____/____/___