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

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
    - ☐ Mental Illness
    - ☐ Gout
    - ☐ High Blood Pressure
    - ☐ Heart Attacks
    - ☐ Kidney Disease
    - ☐ Epilepsy
    - ☐ Allergy
    - ☐ Cancer
    - ☐ Other, list: __________
    - ☐ Spinal Disorder
    - ☐ Diabetes
    - ☐ Arthritis
    - ☐ Migraines
17. Who was the driver of your car? ______________________________
18. Where were you seated in the car? ______________________________
19. Who owns the car you were in? ______________________________

20. Year & Model of your car? ______
Year & Model of the other car? ______
21. Did your airbag deploy? ______
22. What was the approximate damage done to your car? ______
23. Visibility at the time of the accident? ☐ poor ☐ fair ☐ good ☐ other: ______
24. Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other (describe): ______
25. Where was your car struck? ______
26. Please describe the accident in your own words: ______

______
27. Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact ☐ Rear-end car in front of you
☐ Rear impact ☐ Non-collision
28. 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
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:** ______