CHIROPRACTIC HEALTH CENTER
PERSONAL INJURY QUESTIONNAIRE

PATIENT # ___________
DATE: ______________
OFFICE USE ONLY

INFORMATION ABOUT YOU *If you need any help, please ask the receptionist.*

Driver's License # ________________________ Email: ______________________@ __________

NAME ____ PHONE- HOME ___________________

ADDRESS: ____ CITY _________________ STATE______ZIP CODE ____________

AGE _________ BIRTHDATE _________________ SEX ( ) M ( ) F S/S # _______-_______-__________________

MARITAL: M S W D EMERGENCY PHONE: _____________________________________ CELL #: ________________________

EMPLOYER'S NAME: ____

EMPLOYER'S ADDRESS: ____ PHONE: ________________

YOUR INS. CO.: ____

CLAIM/POLICY # ___________________________ PHONE # OF INS. CO.: _______________ AGENT'S NAME __________

NAME ON POLICY (IF OTHER THAN SELF) ____ POLICY #: ___________________________

RESPONSIBLE PARTY'S NAME:____

ADDRESS ____ CITY ___________________ STATE: _______ ZIP ________

POLICY HOLDER'S NAME: ____

PATIENT'S NEAREST RELATIVE (OTHER THAN SPOUSE) _____________________________________ RELATIONSHIP _____________

RELATIVE'S ADDRESS ____ CITY _______________________________ ZIP ______________

HOW WERE YOU REFERRED TO OUR OFFICE? ____

DATE OF LAST PHYSICAL EXAM ____________________ WHAT OPERATIONS HAVE YOU HAD & WHEN? _____________________

____

SERIOUS ILLNESSES: ____

INFORMATION ABOUT YOUR ATTORNEY

NAME: ____ PHONE: ________________________ FAX _______________________

ADDRESS ____ CITY _____________________ STATE __________ ZIP _____________

WERE THERE ANY WITNESSES? ( ) YES ( ) NO NAMES: ____

INFORMATION ABOUT YOUR ACCIDENT

1. DATE OF ACCIDENT ________________ TIME OF DAY____
2. WERE YOU: ( ) DRIVER ( ) PASSENGER ( ) FRONT SEAT ( ) BACK SEAT
3. NUMBER OF PEOPLE IN YOUR VEHICLE? ________________________ WERE YOU WEARING SEAT BELTS? ( ) YES ( ) NO
4. WERE YOU STRUCK FROM: ( ) BEHIND ( ) FRONT ( ) LEFT SIDE ( ) RIGHT SIDE
5. APPROXIMATE SPEED OF YOUR CAR _______ MPH. OTHER CAR _________ MPH
6. WERE YOU KNOCKED UNCONSCIOUS? ( ) YES ( ) NO IF YES, FOR HOW LONG? ____________________________
7. WERE THE POLICE NOTIFIED? ( ) YES ( ) NO WAS A REPORT MADE? ( ) YES ( ) NO IF YES, PLEASE PROVIDE
8. IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT ____
   ____
   ____
9. DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? ( ) YES ( ) NO
   IF YES, DESCRIBE: ____
   ____
   ____
10. PLEASE DESCRIBE HOW YOU FELT:
    a. DURING the accident: ____

b. IMMEDIATELY AFTER the accident: ____________________

c. LATER THAT DAY ____________________

d. THE NEXT DAY: ____________________

11. WHAT ARE YOUR PRESENT COMPLAINTS AND SYMPTOMS? ____________________

____

____

____

____

12. DO YOU HAVE ANY CONGENITAL (FROM BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM?

____

____

13. DO YOU HAVE ANY SERIOUS ILLNESSES WHICH RELATE TO THIS CASE? ( ) YES ( ) NO

IF YES, PLEASE DESCRIBE: ____________________

____

____

14. HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE? ( ) YES ( ) NO

IF YES, PLEASE DESCRIBE: ____________________

____

15. WHERE WERE YOU TAKEN AFTER YOUR CURRENT ACCIDENT? ____________________

16. HAVE YOU BEEN TREATED BY ANOTHER DOCTOR SINCE THE ACCIDENT? ( ) YES ( ) NO

IF YES, NAMES: ____________________

17. SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS ( ) IMPROVING ( ) GETTING WORSE ( ) SAME

18. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT.

[ ]	HEADACHE	[ ]	IRRITABILITY	[ ]	NUMBNESS TOES	[ ]	FACE FLUSHED	[ ]	FEET COLD
[ ]	NECK PAIN	[ ]	CHEST PAIN	[ ]	SHORTNESS-BREATH	[ ]	BUZZING IN EARS	[ ]	HANDS COLD
[ ]	NECK STIFF	[ ]	DIZZINESS	[ ]	FATIGUE	[ ]	LOSS OF BALANCE	[ ]	STOMACH UPSET
[ ]	SLEEPING PROBLEM	[ ]	HEAD IS HEAVY	[ ]	DEPRESSION	[ ]	FAINTING	[ ]	CONSTIPATION
[ ]	BACK PAIN	[ ]	PINS/NEEDLES ARMS	[ ]	LIGHT SENSITIVE EYES	[ ]	LOSS OF SMELL	[ ]	COLD SWEATS
[ ]	NERVOUSNESS	[ ]	PINS/NEEDLES LEGS	[ ]	LOSS OF MEMORY	[ ]	LOSS OF TASTE	[ ]	FEVER
[ ]	TENSION	[ ]	NUMBNESS FINGER	[ ]	EARS RING	[ ]	DIARRHEA	[ ]	__________

SYMPTOMS OTHER THAN ABOVE: ____________________

19. HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT? ( ) YES ( ) NO

a. LAST DAY WORKED: ____________________

b. TYPE OF EMPLOYMENT ____________________

c. PRESENT SALARY____________________

d. ARE YOU BEING COMPENSATED FOR TIME LOST FROM WORK? ( ) YES ( ) NO

IF YES, TYPE OF COMPENSATION YOU ARE RECEIVING: ____________________

20. DO YOU NOTICE ANY ACTITIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ( ) YES ( ) NO

____

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____

21. OTHER PERTINENT INFORMATION: ____________________

____

____

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____________________ ____________________

DATE PATIENT'S SIGNATURE