

Personal Injury Questionnaire

Wellness First Chiropractic

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy# _____ Agent's Name _____

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy# _____

Attorney

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? Yes No If yes, please list name(s) _____

Nature of the 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 a seat belt? _____

4. Which direction were you headed? North South East West

on (name of street) _____

5. Which direction was the other vehicle headed? North South East West

on (name of street) _____

6. Were you struck from. Behind Front Left Side Right Side

7. Approximate speed of car: _____ mph Other car: _____ mph

8. Were you knocked unconscious? Yes No If yes, how long? _____

9. Were police notified? Yes No

10. In your own words, please describe 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 congenial (from birth) factors, which relate to this problem? Yes No If yes, please describe. _____

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

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

- | | | | |
|----------------------------------------------|-----------------------------------------------|---------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Hands cold | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Back pain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Feet cold | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Ears ring |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Nervousness | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Depression | <input type="checkbox"/> Pins and needles in legs | _____ |

21. Have you lost time from work as a result of this accident? Yes No If yes, please answer the following information.

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, 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. _____

PATIENT'S SIGNATURE

DATE