Personal Injury Questionnaire

Name:_________________________________ Date of accident:________________ Time:_____________

Where did the accident happen?____

Describe the accident in your own words:____

____

____

If injury is due to an auto accident, what is the name of your auto insurance company?__________________________
If injury is due to an auto accident, have you filed a claim? **Yes** **No** If yes, what is the claim #?____________________
Claim adjuster name______________________ Contact#_________________ Fax#__________________
If injury is due to an auto accident, do you have an estimate for repair costs of your automobile? **Yes** **No**
If yes, what was the repair estimate?___________ Besides yourself, how many passengers were in the car?_______
Do you have medical pay included in your auto policy? **Yes** **No** If yes, what is your maximum benefit amount?__________
Do you have an attorney representing you for this auto accident? **Yes** **No**

If yes, what's your attorney's name?______________________________ Phone#________________________

What was your position in the vehicle?_________________________________

Was the impact from: **front** **right side** **left side** **rear** Were you braced for impact? **Yes** **No**
At impact were you looking: **straight** **right** **left** Were you wearing your seatbelt? **Yes** **No**
Were both hands on the steering wheel? **Yes** **No** Was your foot in the brake? **Yes** **No**

Where in the car were you after the accident?___________________________________

Did you strike anything in the vehicle at impact? **Yes** **No** If yes, specify:_________________________________
Please state part(s) of body: **chest** **chin** **knee** **shoulder** **hand** **head**

Immediately following the accident, how did you feel?____
Did you go to the hospital? **Yes** **No** If you went to the hospital, when?_____________________
How did you get to the hospital? Ambulance: **Yes** **No** Private transportation: **Yes** **No**
Did the EMT's place you in? Neck Collar: **Yes** **No** Splint: **Yes** **No** Brace: **Yes** **No**

Name of hospital:______________________ Doctor seen:_________________________

Were x-rays taken? **Yes** **No** Were you admitted? **Yes** **No** How long did you stay?__________

What treatment was rendered?____

What recommendations were made?____

Have you seen any other doctor as a result of this accident? **Yes** **No** If yes, Doctor's name____________________
Where do you feel pain?____

Patient Self Assessment: The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** 0 meaning ***no disability*** at all, and 10 meaning that you ***cannot perform*** those activities at all.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Family/Home Responsibilities: activities related to the home or family Including chores and duties performed around the house (yard work, household chores, Errands, favors for other family members, driving children to school, etc.) ________

Recreation: hobbies, sports, and other similar leisure time activities. ________

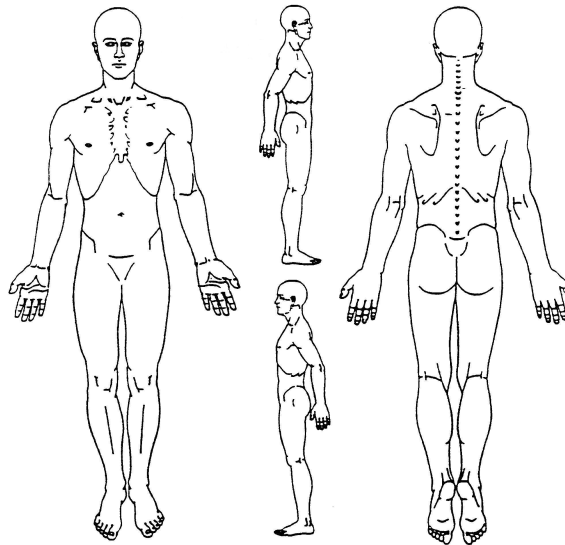
Social Activity: activities which involve participation with friends and acquaintances other than family members including parties, theatre, concerts, dining out, other social functions. ________

Occupation: activities that are a part of or directly related to one's job, including non- paying jobs, such as that of a homemaker or volunteer work. ________

Self Care: activities which involve personal maintenance and dependant daily living (taking a shower, driving, getting dressed, etc.) ________

Life Support Activity: basic life supporting behaviors such as eating, sleeping, and breathing. ________

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example: dull, sharp, constant, off & on, when standing, sitting, walking, etc.



I understand that if this injury is related to an auto accident, I need to provide an accident report, my auto insurance, health insurance and if applicable the liable party's insurance, and attorney information. I fully understand that until necessary insurance information is gathered and verified for Chiropractic Care, I will be required to pay for my care.

________________________ ____________

Patient's Signature/Guardian **Date**