PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

ADDRESS:_____ CITY:_____ STATE:_____ZIP_____

PHONE #:_____ EMAIL ADDRESS:_____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?
☐ Driver: if Driver were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both
☐ Passenger: If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear
Did your vehicle strike another vehicle ☐ Yes ☐ No
Was your vehicle struck by another vehicle ☐ Yes ☐ No
Angles of impact… First Collision: ☐ Front ☐ Back ☐ Left ☐ Right
If Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right
Were you wearing a seat belt? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No … ☐ I braced with my hands ☐ I braced with my feet
Which way were you facing at the time of impact… ☐ straight ahead ☐ Left ☐ Right

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No
If yes, specify what part of your body struck what: ie… head chest chin shoulder Right / Left Knee
☐ Steering Wheel _____ ☐ Dashboard _____
☐ Windshield _____ ☐ Roof_____
☐ Left Side Door _____ ☐ Right Side Door_____
☐ Left Side Window. _____ ☐ Right Window _____
☐ Other _____
Did the seat back bend / break ? ☐ Yes ☐ No
Immediately following the accident, how did you feel? ☐ dizzy/dazed ☐ disoriented ☐ unconscious
☐ nervous ☐ nauseous ☐ upset ☐ weak ☐ Other _____

Did you go to hospital ☐ Yes ☐ No Were you admitted to the hospital? ☐ Yes ☐ No if yes how long? _____
If you went to hospital, when? ☐ At time of accident ☐ Next day
How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation
Name of Hospital:_____
Attended by Dr. _____
… what treatment was given?
☐none ☐placed in a cervical collar ☐x-rayed ☐ given stitches ☐Bandaged
☐ given pain medication ☐given instructions regarding concussions
☐given instructions regarding sprains and strains ☐ Physical Therapy
☐instructed to call a Orthopedic Surgeon ☐instructed to call a private physician
☐referred to this office for treatment ☐ Other _____

Doctor's name

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

CHIEF Complaints or Symptoms: **Name:** **Date:**

☐**Neck pain** check off the areas that the pain runs into from the neck ☐headache ☐Migraine Headache ☐upper back pain	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain / Shoulder pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists / Shoulders
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability ☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night ☐ nightmares ☐difficulty with sleeping at night

☐**Low Back Pain** select the areas of radiation, if any...	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness and/or Tingling:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints: _____

_____

_____

_____

_____

Have You lost any time from work due to your injuries? ☐Yes ☐No

If yes please give dates: _____

Type of employment:

_____

Have you had previous injuries or accidents? ☐Yes ☐ No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? ☐Yes ☐No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____