

## PERSONAL INJURY QUESTIONNAIRE

Thank you for choosing our office for treatment of your injuries. In order to bill the insurance for your accident, we will need ALL your insurance information from you as soon as possible. Thank you for your assistance! **PLEASE PRINT CLEARLY**

PATIENT NAME \_\_\_\_\_ Date \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
STREET APT CITY STATE ZIP  
HOME PHONE \_\_\_\_\_ WK \_\_\_\_\_ CELL \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_ TIME (am/pm) \_\_\_\_\_  
I was (check one)  the Driver  a Passenger  a Pedestrian  Bicyclist  
located at \_\_\_\_\_ In/near \_\_\_\_\_  
Street/Highway location (City)  
Your car:  Hit the other car  Was Hit in the:  Right  Left  Rear  Front  Side  
Type of Accident:  Head-on collision  Rear-end collision  Broad-side collision  
 Front Impact, rear-ended car in front  
Driver of vehicle \_\_\_\_\_ Owner \_\_\_\_\_

Has this accident been reported to the police?  YES  NO  
If yes, did they come to the scene of the accident?  YES  NO  
If yes, did they cite anyone with a traffic violation?  YES  NO  
If yes, whom?  myself  my driver  the other driver

Have you reported this accident to any insurance company?  my own  my driver's  
 the owner of my driver's vehicle  other driver's  the owner of the other driver's  
vehicle

### **PATIENT'S AUTO INSURANCE COMPANY**

NAME \_\_\_\_\_ Phone \_\_\_\_\_ CLAIM # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PO BOX/STREET CITY STATE ZIP

### **INSURED'S AUTO INSURANCE COMPANY (If a Passenger)**

INSURED'S NAME (if other than patient) \_\_\_\_\_ ph \_\_\_\_\_  
INSURANCE \_\_\_\_\_ Phone \_\_\_\_\_ CLAIM # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PO BOX/STREET CITY STATE ZIP

### **OTHER DRIVER'S INSURANCE COMPANY**

OTHER DRIVER'S NAME (if another car was involved) \_\_\_\_\_ ph \_\_\_\_\_  
INSURANCE \_\_\_\_\_ Phone \_\_\_\_\_ CLAIM # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PO BOX/STREET CITY STATE ZIP

### **HAVE YOU RETAINED AN ATTORNEY?** YES NO

NAME \_\_\_\_\_ Phone \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PO BOX/STREET CITY STATE ZIP

Please describe how you felt. (PLEASE BE SPECIFIC)

Immediately AFTER the accident: \_\_\_\_\_

Later that  Day  Night: \_\_\_\_\_

The next day(s): \_\_\_\_\_

Check the symptoms you have noticed SINCE the accident: (check all that apply)

- Headaches  Dizziness  Loss of memory  Sleeping problems  Constipation  
 Neck pain/stiffness  Fainting  Fatigue  Numbness in toes  Chest pain  
 Midback pain/stiffness  Ringing/buzzing in ears  Tension  Numbness in fingers  
 Nervousness  Low back pain/stiffness  Loss of balance  Shortness of breath  
 Irritability  Cold hands  Cold sweats  Sensitivity to light  Loss of smell  
 Anxious  Cold feet  Loss of taste  Depression  Pain behind eyes  
 Other \_\_\_\_\_

### ACTIVITIES OF DAILY LIVING

What daily home activities do you notice that are different NOW than before the accident?  
(Please specify) \_\_\_\_\_

List those activities that you are UNABLE to do: \_\_\_\_\_

List those activities that are PAINFUL to do: \_\_\_\_\_

List those activities that are DIFFICULT to do: \_\_\_\_\_

Did you see the accident coming?  YES  NO

Were you prewarned the accident was about to happen?  YES  NO

Did you brace for impact?  YES  NO

Were seat belts worn?  YES  NO

Were shoulder harnesses worn?  YES  NO

### HEAD/BODY POSITION

Head/body position at time of impact: Head turned:  Right  Left  looking back  
 looking straight ahead  body straight in sitting position

Body rotated:  Right  Left

At time of impact, what parts of your head or body hit the inside of your car? \_\_\_\_\_

Did you seek medical help immediately/soon after the accident?  YES  NO

DOCTOR/HOSPITAL/CLINIC SEEN: \_\_\_\_\_ DATE: \_\_\_\_\_

Were you examined?  YES  NO Were X-Rays Taken?  YES  NO

Were you given treatment of any kind?  YES  NO

If yes, What treatment did you receive? \_\_\_\_\_

Date of last treatment? \_\_\_\_\_

I certify that all the above information is true and accurate to the best of my knowledge. I agree to assist Accident & Injury Chiropractic with any information necessary to process my claim. I also understand that any treatment rendered me is my responsibility.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature (if patient is a minor) \_\_\_\_\_