

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Phone: () _____

Driver's License #: _____

Age: _____ Birthdate: _____ Sex: _____ SSN: _____

Employer's Name: _____ Employer's Address: _____

Your insurance Co: _____ Policy #: _____ Agent's Name: _____

Name of Policy (if other than self): _____ SSN: _____

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 Name(s): _____

NATURE OF ACCIDENT

1. Date of Accident: _____ Time of Day: _____

2. Were you: Driver Passenger Front Seat Back Seat

3. Number of people in vehicle? _____ Were you wearing seat belts? _____

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

on (name of street): _____

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

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

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

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

9. Were police notified? Yes No

10. In your own words, please describe the accident: _____

11. Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

12. What are you PRESENT complaints and symptoms? _____

13. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe: _____

14. Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe: _____

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

16. Where were you taken after the accident? _____

17. 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? _____

18. Since this injury occurred are your symptoms: () Improving () Getting Worse () Same

19. CHECK ANY SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

20. Symptoms other than above: _____

21. Describe any additional complaints and symptoms? _____

22. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No If yes, please describe:

23. Have you lost time from work as a result of this accident? () Yes () No If yes, please state type of compensation you are receiving: _____

24. Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe in details:

25. Other pertinent information:

I understand and agree that health and accident insurance policies are an arrangement between myself and an insurance carrier. I clearly understand and agree that all services rendered at Bazil Chiropractic Health Center are charged directly to me and that I am personally responsible for payment.

Date

Patient's Signature