Discover Chiropractic
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PERSONAL INJURY QUESTIONNAIRE

Name________________________ Phone ( )________________

Address________________ City________________ State____ Zip________

YOUR INSURANCE INFORMATION

Name of your AUTO Ins.________________ Phone ( )________________

Address________________ City________________ State____ Zip________

Policy #________________

Name of your GROUP Ins.________________ Phone ( )________________

Address________________ City________________ State____ Zip________

Group/Policy #________________ Social Security #________ -- ______ -- ______

Name of Attorney________________ Phone ( )________________

Address________________ City________________ State____ Zip________

OTHER PARTY'S INSURANCE INFORMATION

Name of their AUTO Ins.________________ Phone ( )________________

Address________________ City________________ State____ Zip________

Name of Insured________________ Policy #________________

1. Date of Accident________________ Time of Day________________am_____pm_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? __________ Were you wearing seat belts? ( ) Yes ( ) No
4. In which direction were you headed? ( ) North ( ) South ( ) East ( ) West
   on (name of street)________________ City________________
5. In which direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) 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 the police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident: ________________

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

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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? ____________________

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14. Do you have any congenital (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:
____

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: ____________________

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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 the 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 THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Face Flushed	☐ Head Seems Too Heavy	☐ Fainting
☐ Neck Pain	☐ Tension	☐ Lights Bother Eyes	☐ Pins & Needles in Arms	☐ Fever
☐ Stiff Neck	☐ Fatigue	☐ Ringing in Ears	☐ Pins & Needles in Legs	☐ Cold Sweats
☐ Back Pain	☐ Depression	☐ Buzzing in Ears	☐ Numbness in Fingers	☐ Stomach Upset
☐ Chest Pain	☐ Nervousness	☐ Loss of Smell	☐ Numbness in Toes	☐ Diarrhea
☐ Hands Cold	☐ Dizziness	☐ Loss of Taste	☐ Sleeping Problems	☐ Constipation
☐ Feet Cold	☐ Loss of Balance	☐ Loss of Memory	☐ Shortness of Breath	

Symptoms Other Than Above ____________________

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
If yes, please complete the following:
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: ____________________

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23. Other pertinent information: ____________________

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DATE PATIENT'S SIGNATURE