PERSONAL INJURY QUESTIONNAIRE

NAME: Date of Accident:

Describe the accident in your own words:____

____

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☐ Driver: if Driver, were your hands on the steering wheel? ☐ Yes ☐ No

☐ 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 … Did an airbag deploy ☐ Yes ☐ No

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

____

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:____

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 ________________________

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

Doctor's name :____

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

☐**Neck pain** Select the areas of pain radiation, if any:	☐None ☐Left shoulder ☐Left arm ☐Left forearm ☐Left hand ☐Right shoulder ☐Right arm ☐Right forearm ☐Right hand
☐Headache ☐Migraine Headache ☐Upper back pain	

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
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:

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

Additional Symptoms/ Complaints:

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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
Date of previous Accident:

____

Date 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.) ________