PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident_____

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 _____

_____

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** 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	☐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:

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.) _____