Raymond Chiropractic 1702 South 72nd Street Suite A Tacoma, WA 98408 P: (253) 474 – 0677 F: (253) 474 – 3540

PERSONAL INJURY QUESTIONNAIRE

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

PATIENT NAME _____ DATE: _____/_____/_____

DATE OF COLLISION _____ 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 Collision: □ Head-on □ Rear-end □ Broadside/T-boned □ Front impact, Rear-ended car in front

Has this collision been reported to the police? □ YES □ NO

If yes, did they site anyone with a traffic violation? □ YES □ NO

If yes, whom? □ Myself □ My driver □ Other driver

Do you have a copy of the police report? □ YES □ NO

If YES, please provide a copy of your police report for our records.

Please describe how you felt following the collision. (*PLEASE BE SPECIFIC*)

Immediately AFTER the collision: _____

_____

Later that □ DAY □ EVENING: _____

_____

The next day(s): _____

_____

Check the symptoms you have noticed SINCE the collision: (*CHECK ALL THAT APPLY*)

Cervical

□ Neck pain/stiffness
□ Headaches
□ Shoulder pain
□ Arm pain
□ Wrist/hand pain
□ Numbness in fingers
□ Loss of smell/taste
□ Anxiety
□ Fainting
□ Irritability
□ Depression
□ Memory loss
□ Light sensitivity
□ Ringing/buzzing in ears
□ Sleeping problems
□ Fatigue

Thoracic

□ Mid back pain/stiffness
□ Rib pain
□ Shortness of breath
□ Indigestion
□ Chest pain
□ Pain over sternum

Lumbar

□ Low back pain/stiffness
□ Hip pain
□ Buttocks pain
□ Thigh pain
□ Knee pain
□ Leg pain
□ Foot pain
□ Loss of balance
□ Constipation/Diarrhea
□ Loss of bladder control
□ Numbness in toes

Other(s) _____

_____

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ACTIVITIES OF DAILY LIVING

What daily home activities do you notice that are different NOW than before the collision? (*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 collision coming?	□ YES	□ NO
Were you forewarned the collision was about to happen?	□ YES	□ NO
Did you brace for impact?	□ YES	□ NO
Were seat belts worn?	□ YES	□ NO
Were shoulder harness worn?	□ YES	□ NO
Did the air bag deploy?	□ YES	□ NO

HEAD / BODY POSITION

Head / body position at the time of impact: Head turned: □ Right □ Left □ Looking back
□ Looking straight ahead □ Body straight in sitting position
Body rotated: □ Right □ Left
At the 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 collision? □ 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(s) did you receive? _____

_____

Date of last treatment? _____

Follow-up visit / Additional care? _____

_____

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

Patient / *Guardian* Signature _____ DATE: _____/_____/_____

Printed Name _____