FAMILY First CHIROPRACTIC
Changing lives through the power of the chiropractic adjustment.

PERSONAL INJURY QUESTIONNAIRE

Name ______________________________ Phone ______________
Address ______________________ City ____________ State ______ Zip ______
Age ________ Birth date __________ Sex ________ S/S# ______________
Your Ins. Co. __________________________ **Adjuster's Name** __________
Name on Policy (if other than self) ____________________ Their Date of Birth ______
Policy # ______________________ **Claim #** ____________________
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 ________ **State Accident Occurred** __________
2. Were you ❑ Driver ❑ Passenger ❑ Front seat ❑ Back seat
3. Number of people in your vehicle? ________ Were you wearing seat belts? ❑ Yes ❑ No
4. What direction were you headed? ❑ North ❑ South ❑ East ❑ West
   On (name of street) ______________________________
5. What direction was the other vehicle headed? ❑ North ❑ South ❑ East ❑ West
   On (name of street) ______________________________
6. Were you struck from: ❑ Behind ❑ Front ❑ Left ❑ Right
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 accident: ______________________________
    ____
    ____

11. Did you have any physical complaints **BEFORE THE ACCIDENT**?
❑ Yes ❑ No If yes, please describe in detail: ______________________________
____
____

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? ______________________________
____
____
____
____

FAMILY *First* CHIROPRACTIC

Changing lives through the power of the chiropractic adjustment.

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:

____

____

____

____

17. Where were you taken after the accident? ____

18. Have you been treated by another doctor since the accident? ❑ Yes ❑ No

19. Since this injury occurred, are you symptoms: ❑ improving ❑ getting worse ❑ same

20. Check the symptoms you have noticed since the accident:

❑ Headache	❑ irritability	❑ numbness in toes	❑ face flushed	❑ feet cold
❑ Neck pain	❑ chest pain	❑ shortness of breath	❑ buzzing in ears	❑ hands cold
❑ Neck stiff	❑ dizziness	❑ fatigue	❑ loss of balance	❑ stomach upset
❑ Sleeping	❑ head seems too heavy	❑ depression	❑ fainting	❑ constipation
❑ Back pain	❑ pin, needles in arms	❑ lights bother eyes	❑ loss of smell	❑ cold sweats
❑ Nervousness	❑ pins, needles in legs	❑ loss of memory	❑ loss of taste	❑ fever
❑ Tension	❑ numbness in fingers	❑ ears ring	❑ diarrhea	

❑ Symptoms other than above: ____

21. Have you lost time from work as a result of this accident? ❑ Yes ❑ No
If yes, please complete this questions:

a) Last day worked: ____
b) Type of employment: ____
c) Present salary: ____
d) Are you being compensated for time lost from work? ❑ Yes ❑ No
e) If yes, please state type of compensation you are receiving: ____________________

22. So you notice an activity restriction as a result of this injury? ❑ Yes ❑ No
If yes, please describe in detail: ____

____

____

23. Other pertinent information: ____

____

____

Date: ________________ Patient's Signature: ____