PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of Accident: _____

Where did the 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 the vehicle at the 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 □ Left Side Window
□ Right Side Door □ 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 the hospital? □Yes □ No
Were you admitted to the hospital? □ Yes, for how long? _____ □ No
How did you get to the hospital? □ Ambulance □ Police Car □Private Transportation
Name of hospital: _____
Attended by Dr. _____
Treatment given: □ none □ placed in cervical collar □ x-rayed □ given stitches □ bandaged
□ given pain medication □ given instructions regarding concussions □ physical therapy
□ given instructions regarding sprains and strains □ instructed to call an Orthopedic Surgeon
□ instructed to call a private physician □ referred to this office for treatment
□ Other: _____
Have you seen any other doctor because of this accident**?** □ Yes □ No
Doctor's names: _____
_____

Chief complaints or symptoms: Name_____ Date:_____

□ Neck Pain: check off the areas that pain runs from the neck

□ None
□ Left shoulder □ left arm □ left forearm □ left hand
□ Right shoulder □ right arm □ right forearm □ right hand

□ Headache
□ Migraine
□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 □ Depression □ Nightmares □ Nervousness □ Jaw Clenching □ Anxiety
□ Fatigue □ Excessive irritability □ Grinding of teeth at night □ difficulty sleeping at night
□Fear of driving in a car □ A loss of concentration □ Other: _____

□ 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

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.) _____
_____