Hornickel Chiropractic Clinic

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Personal Injury Questionnaire

Your Ins. Co._____ Policy #_____
Agent's name_____
Name on policy (if other than self)_____
Responsible party's name_____ Policy #_____
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_____
2. Were you: ( )Driver ( )Passenger ( )Front seat ( )Back seat
3. Number of people in your vehicle?__Were you wearing seat belts?_____
4. What direction were you headed?( )North ( )South ( )East ( )West on what 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 side ( )right side
7. Approximate speed of your car ___mph Other car ___mph
8. Were you knocked unconscious? ( )Yes ( )No If yes, how long were you unconscious? _____
9. Were police notified? ( )Yes ( )No
10. In your own words, give a DETAILED description of the accident:

_____
_____
_____
_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No If yes, please describe in detail:

_____
_____

12. Please describe what symptoms 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?_____

_____

_____

14. Do you have any previous illnesses which relate to this case? ( )Yes ( )No If yes, please describe:_____
15. Have you ever been involved in an accident before? ( )Yes ( )No If yes, please describe:_____
16. Where were you taken after the accident?_____
17. Have you been treated by another doctor since the accident: ( )Yes ( )No If yes, please list the doctor's name and address: _____

_____

What type of treatment did you receive? _____

_____

18. Since this injury occurred, are your symptoms ( )improving ( ) getting worse ( )staying the same
19. CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

Headaches	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
Sleep problems	Depression	Head feels too heavy	Fainting	Constipation
Back pain	Loss of smell	Light bothers eyes	Tingling in arms	Cold sweats
Nervousness	Fever	Loss of memory	Tingling in legs	Loss of taste
Tension	Ears ring	Tingling in hands	Diarrhea	Other

Symptoms other than above _____

20. Have you lost time from work as a result of this accident ( )Yes ( )No If yes, please explain_____

_____

a. Last day worked _____

b. Type of employment_____

c. Are you being compensated for time lost from work? ( )Yes ( )No If yes, please describe, in detail:_____

_____

_____

21. Do you notice any activity restrictions as a result of this injury?( )Yes ( )No If yes, please describe, in detail:_____

_____

_____

_____

_____ _____

Date Patient's signature