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 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 Side 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 ☐No
If yes how long? _____
If you went to hospital, when? ☐At time of accident ☐Next Day
How did you get to the hospital? ☐Ambulance ☐Police Car ☐Private Transportation
Name of Hospital: _____
Attended by Dr. _____
What treatment was given?
☐None ☐placed in a cervical collar ☐x-rays ☐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 names

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 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 ☐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% ect.) _____