PERSONAL INJURY QUESTIONNAIRE

NAME: _____DOB: _____ Date:_____
Date of Accident_____
Where did 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 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 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 hospital? Ambulance Police Car Private Transportation
Name of Hospital:_____
Attended by Dr. _____
… what treatment was given?
☐none ☐placed in a cervical collar ☐x-rayed ☐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 name/address

CHIEF Complaints or Symptoms

Name:_____**DOB:** _____**Date:**_____
Accident Date:_____

☐**Neck pain**
select areas of radiation, if any:
☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand
☐right shoulder ☐right arm ☐right forearm ☐right hand

☐headache
☐Migraine Headache
☐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 ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night
☐nightmares ☐difficulty with sleeping at night

☐**Low Back Pain**
select 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% etc.)_____