



PERSONAL INJURY/ACCIDENT QUESTIONNAIRE

Last Name _____ First Name _____ SS# _____ DOB _____

Home Phone () _____ Work Phone () _____ Gender ___ Marital Status S M W D

Address _____ City _____ State _____ Zip _____

Reason for Office Visit: _____ AUTO ACCIDENT _____ SLIP & FALL _____ OTHER

Important: If your injury is the result of an *Auto Related Accident* please complete **Section A** as well as the other sections. If your injury is not auto related please skip **Section A** and proceed to **Section B**.

SECTION A: AUTO ACCIDENT (please complete SECTION A only if your injury is a result of an auto accident)

Nature of accident

of people in car _____; Approximate speed of car _____ mph; Other car's speed _____ mph;

Date of accident ___/___/___ Time: _____; Location of accident: _____;

Were there any witnesses? Yes No

If yes, names of witnesses _____

Describe accident in your own words:

What was your position in car ___ Driver ___ Passenger If Passenger, were you sitting in ___ Front ___ Right Rear ___ Left Rear

Did your vehicle strike the other vehicle Yes No Was your car struck by other vehicles? Yes No

Was impact from _____ the Front? _____ the Right? _____ the Left? _____ the Rear?

At time of impact were you _____ Looking straight ahead? _____ Looking right? _____ Looking left?

Were both hands on steering wheel? Yes No Was your foot on the brake? Yes No

Were you braced for impact? Yes No Where in the car were you after the accident? _____

Were you wearing seat belts? Yes No Did you strike anything in the vehicle at time of impact Yes No

If Yes specify: ___ Steering wheel ___ Dashboard ___ Windshield ___ Side Door ___ Arm Rest ___ Side Window ___ Other

Please state part of body: ___ Chest ___ Chin ___ Knee ___ Shoulder ___ Hand ___ Head ___ Other

SECTION B:

Your Insurance Company _____ Phone # _____ Policy # _____

Responsible Party's Name & Address _____

Policy Holder's Name _____ Policy# _____

Nature of Accident:

Where did the accident happen? _____ Were there witnesses? Yes No

If yes, provide names _____

Describe the accident in your words _____

Immediately following the accident, how did you feel? _____

Were you unconscious? Yes No In a daze? Yes No

Did you go to the hospital? Yes No

If you went to the hospital, when? At time of accident Yes No Private transportation Yes No

Did the ambulance attendants place you in a Neck Collar? Yes No Splints? Yes No Brace? Yes No

Name of Hospital _____ Name of Doctor _____

Were you X-Rayed Yes No

If so, what was the Diagnosis? _____ Were you admitted to the Hospital Yes No

If yes, how long was your stay _____

What treatment was rendered? _____

What recommendations were made? _____

Have you retained an attorney? Yes No

If yes, whom: _____ Address: _____ Phone: _____

Have you seen any other doctor as a result of this accident? Yes No

If yes, Doctor's name and address _____

Is your pain constant? Yes No Is the pain on and off? Yes No Sharp? Yes No Dull? Yes No

Describe the pain in your own words _____

Is your pain worse when rising from a chair? Yes No By straining? Yes No By coughing Yes No

By sneezing Yes No By straining when moving bowels? Yes No

Do you have any numbness or tingling in your arms? Yes No

Hands? Yes No Fingers? Yes No Legs? Yes No Feet? Yes No Toes? Yes No

What is your most comfortable position? Sitting? Yes No Lying on your right side? Yes No

Lying on left side? Yes No Lying on your back? Yes No On your stomach? Yes No

Standing? Yes No Other _____

Is it difficult for you to move around the bed? Yes No Does stretching and twisting worsen the pain? Yes No

Do any of the following relieve your pain? ___Heating Pad ___Hot Pad ___Shower ___Ice Pack ___Medication

Does a brace (f you've tried one) relieve the pain? Yes No

Does a change in heel height worsen the pain Yes No

Do you feel better moving around? Yes No Or resting? Yes No

Do you have a firm mattress? Yes No

Do your knees ache or hurt? Yes No Do you have cramps in your legs or arms? Yes No Specify _____

Have you had any changes in your bowel habits? Yes No

Have you ever been in any previous accident or have any illness which relates to this case Yes No

If yes, please describe: including date(s) and type(s) or accidents as well as injuries received:

CHECK SYMPTOMS YOU HAVE NOTICED SINCE YOUR INJURY:

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Lights Bother eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Please list any other symptoms you are experiencing _____

Employer's Name _____

Employer's Address _____

Have you lost time from work as a result of this injury? Yes No If yes, please complete this question

A: Last Day Worked: _____

B: Type of Employment: _____

C: Present Salary: _____

D: Are you being compensated for your lost time at work? Yes No

If yes, please state type of compensation you are receiving: _____

Do you notice any activity restrictions as a result of this injury? Yes No

If yes, please describe in detail _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand, that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

DATE

PATIENT'S SIGNATURE