Personal Injury Questionnaire

Full Name: _____ Phone: _____

Address: _____

City: _____ Zip: _____ Birth Date: _____

Age: _____ Sex: _____

Accident Information: In your words, please describe the accident in detail.

_____

_____

_____

_____

_____

_____

Date of Accident: _____ Time: _____ am / pm

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

How many passengers were in the car with you? _____

Was there a Police Report? ( ) Yes ( ) No

Check Symptoms You Have Noticed Since the Accident:

Headache	Pins & Needles in Legs	Loss of Balance
Neck Pain	Numbness in Fingers	Fainting
Neck Stiff	Numbness in Toes	Loss of Smell
Sleeping Problems	Shortness if Breath	Loss of Taste
Back Pain	Fatigue	Diarrhea
Nervousness Tension	Depression	Feet Cold
Irritability	Lights Bother Eyes	Hands Cold
Chest Pain	Loss of Memory	Stomach Upset
Dizziness	Ears Ring	Constipation
Head Seems Too Heavy	Face Flushed	Cold Sweats
Pins & Needles in Arms	Buzzing in Ears	Fever

Symptoms Other Than Above _____

_____

_____

Did you receive any other medical/chiropractic care directly after the accident?

( ) Yes ( ) No

If yes, please describe: _____

_____

_____

Please describe your PRESENT symptoms and complaints: _____

_____

_____

_____

Since the car accident, have your symptoms:

( ) improved ( ) stayed the same ( ) gotten worse

Do you notice restrictions in any other area of you life as a result of this accident?

_____

_____

Have you lost any time from work as a result of the accident? ( ) Yes ( ) No

Did you have any physical complaints before the accident? ( ) Yes ( ) No

If yes, please describe: _____

_____

Other pertinent information: _____

_____

_____

_____

Signed _____ Date _____

Legal Guardian (if applicable) _____ Date _____