Personal Injury Questionnaire

Dear Patient: Date: ___________________

We need this confidential information answered completely to help assess your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

General Information

Name ____________________ Sex ___ Marital Status ____ Date of Birth _________ Home Phone __________

Address ____ City ______________________ State ___ Zip ______

Occupation ____ Work Phone ___________ Ok to call there? ____

Nature of Accident

1. What was the time and date of this present injury? _____AM _____PM Date ________________

2. Please explain in detail how your accident happened. (Please indicate location, equipment, and conditions)

3. Did you come into contact with any objects? ☐Yes ☐No

   If yes, what objects (i.e. door, cabinet) ____

4. What parts of your body came in contact with the above object(s)?

5. Where did you feel pain or unusual feeling immediately after the accident?

6. Were you unconscious as a result of the accident? ☐Yes ☐No If yes, how long? ________

7. Were you bleeding as a result of the injury? ☐Yes ☐No

8. Did you consult any other doctor? ☐Yes ☐No

   Doctor's name? ____ ☐DC ☐MD ☐DO ☐DDS

9. Describe the doctor's diagnosis ____

10. What treatment did you receive? ____

11. Are you still under a doctor's care? ☐Yes ☐No

    If yes, please explain ____

Past History

1. Have you ever injured this area before? ☐Yes ☐No If yes, when? ___________________

2. If injured before, did you lose time from work? ☐Yes ☐No

3. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? ☐Yes ☐No If yes, please explain dates and details

____

4. Have you been treated previously by a chiropractor? ☐Yes ☐No

    If yes, please explain ____

Present Information/Disability

1. Have you returned to work? ☐Yes ☐No If yes, date returned to work _____________________

2. Job description ____

3. Do you favor any part of your body in your work? ☐Yes ☐No

    If yes, please explain ____

4. Are your work activities restricted as a result of this accident? ☐Yes ☐No

    If yes, please explain ____

5. Since this injury, are your symptoms: ☐improving ☐getting worse ☐the same

    Please explain ____

6. Do any other diseases or accidents affect your employment? ☐Yes ☐No

    If yes, please explain ____

Legal Representation

1. Have you retained an attorney? ☐Yes ☐No

    If yes, name _________________________________

    Address ____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ ____________________

Patient Name Date

____ ____________________

Doctor's Signature (upon review) Date