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ADVANCED CHIROPRACTIC CLINIC

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Phone #: _____

Address: _____
Street City State Zip

Details of the Accident
(please circle appropriate responses):

1. Date of Accident: _____ Time of Day: _____ AM / PM
2. Road conditions: Dry Wet Icy Gravel Road Pavement Other: _____
3. Were you: Driver Passenger Front Seat Back Seat
4. What direction were you headed? North South East West
   On (name of street): _____
5. Were you struck from: Front Rear Left Side Right Side
6. Were you aware of the impending collision? Yes No
7. Did you lose consciousness (black out)? Yes No
   If yes, approximately how long were you unconscious? _____
8. Were you wearing a seatbelt at the time of the accident? Yes No
   If yes, what type of belt were you wearing? Lap Belt Shoulder Belt Shoulder & Lap Belt
9. Did the accident trigger air bag release? Yes No
10. Describe the position of your head rest or seat back relative to the position of your ears at impact: Above Below
    Number of inches above or below: _____
11. List the year, make and model of the vehicle you were in at the time of the accident:
    Year: _____ Make:_____ Model: _____
12. Was the vehicle you were in at the time of impact: Stopped Moving
    If stopped, was the driver's foot on the brake? Yes No
    If moving, estimate the approximate speed of the vehicle: _____
13. In your own words, please describe the accident:

14. Were the police notified of the accident? Yes No
15. Please describe what happened to you following the accident (i.e. transported to the hospital by ambulance, taken to hospital by friend, etc.):

16. Please describe any bleeding cuts or bruises received as a result of your accident:

17. Please describe if any of your body parts struck any part of the vehicle. For example, head hit windshield, chest hit steering wheel, etc.:

18. Was your head pointed straight ahead at the time of the accident? Yes No
    If no, which direction was it turned and by how much? _____

19. Was your torso pointed straight ahead at the time of the accident? Yes No
    If no, which direction was it turned and by how much? _____

20. Which of the following vehicle parts broke during the accident:
    Windshield Rt./Lt Window Front/Back Seat Steering Wheel Other: _____

21. What was the cost of damage to the vehicle you were in? _____

The following questions pertain to the other vehicle involved in the accident.

1. What was the year, make and model of the other vehicle?
   Year: _____ Make:_____ Model: _____
2. Was the other vehicle moving at the time of the collision? Yes No
   If yes, what was the vehicle's approximate speed: _____
3. If the other vehicle was moving at the time of the accident, was it:
   Slowing Down Gaining Speed Traveling at a Steady Speed

Health History Questions

1. What are your complaints or symptoms (since the accident):

2. Did you have any physical complaints BEFORE THE ACCIDENT? Yes No
   If yes, please describe in detail:

3. Have you received treatment for this injury since the accident? Yes No
   If yes, please list the doctor's name and address and describe the type of treatment received:

4. If you have been in previous auto accidents or have received treatment for any other significant injuries other than described above, please list the type of accident or injury and the approximate dates below:

To the best of my knowledge, the information provided above is true and correct.

Patient Signature: _____ Date: _____