CHIROCONCEPT
CHIROPRACTIC & REHABILITATION

1900 116th Avenue NE Ste. 200
Bellevue, WA 98004
(425) 243-7966

PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION

Name _____ (FIRST) (LAST)
Address _____
City _____
State _____ Zip_____

Date of Birth _____
Social Security No. _____-_____-_____
Home Phone (_____)_____
Work Phone (_____)_____
Cell Phone (_____)_____

INSURANCE INFORMATION

1. Your Insurance Company _____
2. Did you report the claim to your insurance? (circle one) NO YES
3. Adjuster's Name _____ Phone_____
4. Policy # _____
5. Claim # _____

1. Driver's Name (other vehicle) _____
2. Insurance Company _____
3. Policy # _____
4. Were there any witnesses? NO YES. Name _____
5. Have you retained an attorney? NO YES. Name _____
6. Were the Police notified? NO YES. Officer _____

ACCIDENT INFORMATION

1. Date of Accident _____ Time of Day _____ AM/PM
2. Were you the: ☐ Driver ☐ Front Passenger ☐ Back Passenger
3. Number of people in *your* vehicle _____ Number of people in *other* vehicle _____
4. Road conditions at time of accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other(s) _____
5. Road surface: ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other(s) _____
6. What direction were you headed: ☐ North ☐ South ☐ East ☐ West Street Name_____
7. Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side
8. Were you wearing a seat belt? NO YES If Yes: ☐ Lap belt only ☐ Shoulder belt only ☐ Shoulder and lap belt
9. Any bruising or soreness from the seat belt? NO YES. Explain _____
10. What was your position at the time of impact: ☐ Facing straight ahead ☐ Head turned: (circle one) Left or Right
11. Did your car have a headrest? NO YES. How far was the top of the headrest from the top of your head: _____ inches
12. Were you knocked unconscious? NO YES. For how long? _____
13. Were you aware of the approaching collision prior to impact? NO YES. Did you try to brace yourself for impact? NO YES. How?
_____
14. Was your car stopped at the moment of impact? NO YES
If Yes, was the driver's foot on the brake pedal? NO YES Clutch pedal? NO YES
If Yes, did your car move forward upon impact? NO YES
If No, were you: ☐ Gaining speed ☐ Slowing down ☐ Traveling at a steady speed: (circle one) Slow Medium Fast
15. Did your vehicle strike another car or object? NO YES. Explain _____
16. Was the other vehicle moving at the time of collision? NO YES
If Yes, was the other vehicle traveling: ☐ Slow ☐ Medium ☐ Fast at time of impact
If Yes, was the other vehicle: ☐ Gaining speed ☐ Slowing down ☐ Traveling at a steady speed
17. What type of car were you driving? _____
18. What type of car was the other vehicle? _____
19. In your own words, please describe the accident (heard, saw, felt, etc.): _____
_____
20. Please describe how you felt. Did you feel pain/symptom(s):
During the accident? _____
Immediately after the accident? _____
Later that day? _____
The next day? _____
21. What is the estimated cost of damage to your vehicle: $_____
22. Do you have a photo of the damage? NO YES
23. On what part of the automobile did the following body parts hit: (check all that apply)
☐ Head ☐ Chest ☐ Left/Right shoulder ☐ Left/Right arm
☐ Left/Right hip ☐ Left/Right leg ☐ Left/Right knee ☐ Other(s) _____
24. Which of the following car parts broke during the accident: ☐ Windshield ☐ Left/Right side window ☐ Steering wheel
☐ Front seat ☐ Back seat ☐ Other(s) _____
25. Did you have any physical complaints BEFORE the accident? NO YES. If Yes, please describe in detail _____
_____
_____

26. What are your PRESENT complaints & symptoms: _____

_____

27. Do you have any congenital (from birth) factor(s) which relate to this problem? NO YES. Explain _____

28. Do you have any previous illnesses relating to this case? NO YES. Explain _____

29. Have you ever been involved in an accident before? NO YES. Describe (dates, accident types, injuries, etc.) _____

_____

_____

30. Did you receive medical care within a few hours following the accident? NO YES. Where, treatment, doctor's name: _____

_____

31. Have you been treated by any other doctor since the accident? NO YES. List doctor's name & address: _____

_____

32. What type of treatment did you receive? _____

33. Since the injury, are your symptoms: ☐ Improving ☐ Same ☐ Getting worse

34. Check ALL symptom(s) that you have noticed since the ACCIDENT:

___ Headache	___ Shoulder pain	___ Loss of smell	___ Sleeping problems	___ Ears ringing
___ Neck pain	___ Elbow pain	___ Dizziness	___ Head feels heavy	___ Face flush
___ Neck stiffness	___ Wrist pain	___ Fainting	___ Pins & needles in arms	___ Cold sweats
___ Upper back pain	___ Arm pain	___ Fever	___ Pins & needles in legs	___ Depression
___ Mid back pain	___ Leg pain	___ Ears ring	___ Numbness in fingers	___ Nervousness
___ Low back pain	___ Chest pain	___ Irritability	___ Numbness in toes	___ Cold feet
___ Hip pain	___ Loss of taste	___ Fatigue	___ Shortness of breath	___ Cold Hands
___ Knee pain	___ Loss of memory	___ Diarrhea	___ Lights bother eyes	
___ Foot pain	___ Loss of balance	___ Constipation	___ Emotions out of control	

Other symptom(s) not listed above: _____

WORK INFORMATION

1. Employer: _____
2. Type of employment: _____
3. Have you missed time from work as a result of this accident? NO YES
   If Yes, when was the last day worked? _____ Number of days missed _____
   If Yes, are you being compensated for time lost from work? NO YES
   If Yes, type of compensation you are receiving: _____
4. Do you notice any activity restrictions in your capacity to work, family or recreation as a result of this injury? NO YES. Describe below:

_____

_____

OTHER RELEVANT INFORMATION

_____

_____

← SIGN HERE

PATIENT'S SIGNATURE DATE

FOR OFFICE USE ONLY

Doctor's Notes