# Personal Injury Questionnaire

**Please PRINT CLEARLY - All information is required & kept confidential.**

**Please provide us with your:** • **Auto Insurance info** • **Health Insurance cards** • **Driver's License** • **All Police, Medical, Accident Reports**

## Who referred you to our Center ? **Print Full Name of patient, doctor, attorney, website, directory or event**

☐Referred by* ☐Internet website* ☐Health Fair/Event* ☐Yellow Pages* ☐Met Doctor* ☐Drove by

*Name: ____________________

## Patient Information

**Patient's First & Last Name:** ____________________

Date of Birth: __________ Gender: Male Female Marital Status: single married widowed divorced

Address: ____________________ Apt/Suite#: _____ City: __________ State: ___ Zip: _____

Home Phone #: ( ) ____________________ Cell/Pager/Other #: ( ) ____________________

Email address: ____________________

Social Security #: ____________________ Driver's License #: ____________________

**Emergency Contact Name:** ____________________ Tel #: ( ) __________

Relationship to Patient: ____________________

Address: ____________________ Apt/Suite#: _____ City: __________ State: _____ Zip: _____

Home Phone #: ( ) ____________________ Cell/Pager/Other #: ( ) ____________________

Work Phone #: ( ) __________ Extension: _______ Email: ____________________

## Patient Employment Information

☐ Not employed ☐ Student ☐ Self-employed→Business Name: ____________________

Employer/School: ____________________ Occupation: ____________________

Address: ____________________ Apt/Suite#: ____ City: __________ State: ____ Zip: _____

Work Phone #: ( ) __________ Extension: _______

## Patient Health Insurance Information

**Do you currently have Health Insurance:** ☐ No ☐ Yes→ Complete below

**Name of Insured/Subscriber:** ____________________

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Legal Guardian ☐ Other: __________

Insurance Company: ____________________

Plan Type: ☐ PPO ☐ HMO ☐ Medicare ☐ Other: ____________________

ID #: __________ Policy #: __________ Group #: __________

Insurance Tel # (on back of card): ( ) ____________________

Name of Primary Care Doctor: ____________________ Tel #: ( ) __________

## Patient's Attorney Information

**Have you hired an attorney:** ☐No ☐Yes→ Attorney First & Last Name: ____________________

Law Firm/Office Name: ____________________

Paralegal/Assistant's Name: ____________________

Address: ____________________ Suite#: _____ City: __________ State: ____ Zip: _____

Home Phone #: ( ) ____________________ Cell/Pager/Other #: ( ) ____________________

Work Phone #: ( ) ____________________ Extension: _______

Fax: ( ) ____________________ Email address: ____________________

## A. Incident Details

**Please check ONE box that relates to your type of injury case:**

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Bus ☐ Metro Rail ☐ Boat ☐ Train
☐ Pedestrian ☐ Slip/Trip/Fall ☐ Amusement Park ☐ Work related
☐ Other:______________________________________________

1) **Incident Occurred on**: Date: ___________ Time: ______ AM/PM City & State: ______________
Street/Freeway Intersection or Location:______________________________________________

______________________________________________

2) **Describe the incident in your own words using specific details:**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

3) **Draw a diagram of the incident scene. Show positions of all parties involved**: e.g.[V1]=Your vehicle
[V2]=Other vehicle

4) **After the first collision, there was a:** ☐ second collision ☐ third collision ☐ more than 3 collisions

5) **What type(s) of collision/incident was involved: CHECK ALL THAT APPLY:**
☐ Two-vehicle crash ☐ Three or more vehicles ☐ Rear-end crash ☐ Head-on crash ☐ Rollover
☐ Tailbone/side crash ☐ Hit guardrail/tree ☐ Ran off road ☐ Not sure
☐Other:______________________________________________

6) **Did police/authorities arrive on scene:** ☐No ☐Yes→Was a written report made: ☐No ☐Yes
7) **Do you have a police/injury report copy**: ☐No ☐Yes→______________________________
8) **Traffic/Violation issued by police/authorities**: ☐No ☐Yes→To whom: ____________________
9) **Were photos taken of vehicles/accident scene**: ☐No ☐Yes→Who took photos:______________
10) **Did you speak to anybody or did anybody approach you**: ☐No ☐Yes→___________________
11) **Were there any witnesses to the accident**: ☐No ☐Yes→Witness Names & Tel. numbers:

______________________________________________

## B. Your Vehicle Information

1) **Were you in a vehicle that belonged to your company of employment** (e.g. company car) ☐No ☐Yes
2) **Number of people in your vehicle (including yourself)**: __________
3) **Was anyone else in your vehicle injured or hurt**: ☐No ☐Yes→______________________
4) **Were you**: ☐ Driver ☐ Front center passenger ☐ Front right passenger
☐ Rear right passenger ☐ Rear center passenger ☐ Rear left passenger ☐ Pedestrian
5) **Seatbelt worn**: ☐No ☐Yes **Headrest:** ☐No ☐Yes
**Airbags deployed**: ☐No ☐Yes→ ☐ Driver bag ☐ Front Passenger bag ☐ Side bag ☐ "Curtain" bags
6) **Direction vehicle was heading**: ☐ NORTH ☐ SOUTH ☐ EAST ☐ WEST
on (name of street):______________________________________________
7) **Were you hit from**: ☐ BEHIND ☐ FRONT ☐ LEFT SIDE ☐ RIGHT SIDE
8) **Have you taken your vehicle to an auto body shop**: ☐No ☐Yes→Damage Estimate: $__________
☐total loss
9) **Was your car towed:** ☐No ☐Yes **Do you have a rental car already:** ☐No ☐Yes

10) **Was there any part inside OR outside your vehicle that broke, bent or was damaged** (eg: car seat back, mirrors, windows, doors, etc..): ☐No ☐Yes→ ______

11) **Your Vehicle Make**: ______ **Model**: ______ Speed of Travel (mph): ______
☐small car ☐mid-size car ☐full-size car ☐pick up truck ☐SUV ☐van ☐large truck/bus/semi
Owner's name: ______ Driver's name: ______

## C. Your Auto Insurance Information

**<u>**Please provide us with your Auto Insurance Declaration Cover Page**</u>**

Auto Insurance Company Name: ______ Insurance Policy #: ______
Tel.#: (   ) ______ extension: ______ Fax.#: (   ) ______
Name of policy owner: ______ Social Security #: ______
Relationship to injured patient: ______

1) **Have you been contacted by <u>any</u> insurance company**: ☐No ☐Yes→ ______

2) **Have you reported your injury to <u>your</u> insurance:** ☐No ☐Yes→ ______
Insurance/Accident Claim #: ______
Claims Adjuster Name (whom you spoke with): ______
Address to mail claim: ______ City: ______ State: ______
Tel.#: (   ) ______ extension: ______ Fax.#: (   ) ______

3) **Has your auto insurance rep seen your damaged vehicle:** ☐No ☐Yes → ☐total loss
Damage Estimate/Details: $ ______

4) **Do you have <u>Medical Payment/Med Pay</u> on your policy:** ☐Don't know ☐No ☐Yes → $ ______

5) **Do you have <u>Uninsured Motorist</u> coverage on your policy:** ☐Don't know ☐No ☐Yes → $ ______

## D. Other Vehicle Information

☐ **Hit & Run accident** (information unknown about other vehicle)

1) **Make**: ______ **Model**: ______ **Speed of Travel** (mph): ______
☐small car ☐mid-size car ☐full-size car ☐pick up truck ☐SUV ☐van ☐large truck/bus/semi

2) **Direction <u>OTHER</u> vehicle was heading**: ☐ NORTH ☐ SOUTH ☐ EAST ☐ WEST
on (name of street): ______

3) **Was the <u>OTHER</u> driver**: ☐speeding ☐intoxicated ☐driving recklessly ☐using cell phone
☐none of these ☐other: ______

4) **Was the <u>OTHER</u> driver's vehicle towed**: ☐No ☐Yes→ ______

5) **Owner's name**: ______ **Driver's name**: ______
**Auto Insurance Company Name**: ______ Insurance Policy #: ______
Tel.#: (   ) ______ extension: ______ Fax.#: (   ) ______
Name of policy owner: ______ Social Security #: ______
Relationship to <u>OTHER</u> driver: ______

## E. Your Current Injuries & Symptoms due to Incident

1) **<u>Please describe how you felt...[e.g. cuts, scrapes, bruises, pain, stiff, sore, emotions, etc..]</u>**
**IMMEDIATELY AFTER the incident**: ☐unconscious ☐ dizzy/dazed ☐disoriented
☐nervous ☐nauseous ☐upset ☐weak ☐other: ______
______

**LATER that day**: ______

**The NEXT day**: ______

2) CURRENT COMPLAINTS: Check **ALL** symptoms you have noticed since the incident:

***Note Your Current Intensity of Pain (0=no pain through 10=constant severe pain).**

***CIRCLE R=right OR L=left OR BOTH**

| | | | | |
|---|---|---|---|---|
| ☐*Head pain=__/10 | ☐jaw/TMJ pain | ☐impatient | ☐face flushed | ☐feet cold |
| ☐*Neck pain=__/10 | ☐chest pain | ☐shortness of breath | ☐buzzing in ears | ☐hands cold |
| ☐*Upper back pain=__/10 | ☐eye pain | ☐coughing | ☐hiccups | ☐fever |
| ☐*Mid back pain=__/10 | ☐abdominal pain | ☐tension | ☐grinding teeth | ☐vomiting |
| ☐*Low back pain=__/10 | ☐jaw clenching | ☐irritability | ☐nervous | ☐restless |
| ☐*R/L Shoulder pain=__/10 | ☐dizziness | ☐fatigue | ☐loss of balance | ☐stomach upsets |
| ☐ *R/L Elbow pain=__/10 | ☐head is "heavy" | ☐depression | ☐fainting | ☐constipation |
| ☐ *R/L Wrist pain=__/10 | ☐mood swings | ☐light sensitivity | ☐loss of smell | ☐cold sweats |
| ☐ *R/L Hip pain=__/10 | ☐disoriented | ☐loss of memory | ☐loss of taste | ☐hot sweats |
| ☐ *R/L Knee pain=__/10 | ☐unconscious | ☐ringing in ears | ☐diarrhea | ☐anxiety |
| ☐ *R/L Ankle pain=__/10 | ☐headaches | ☐blurred vision | ☐confused | ☐difficulty sleeping |
| ☐ *R/L Foot pain=__/10 | ☐difficulty swallowing | | ☐fear of driving/entering a vehicle | |
| | ☐ loss of concentration/difficult to focus on tasks | | | ☐ nightmares |

☐ **Broken bones**→regions:______________________________

☐ **Open cuts/Scrapes**→regions:______________________________

☐ **Bruising (blue/red discoloration)**→regions:______________________________

☐ **Muscle spasms**→regions:______________________________

☐ **Muscle Weakness**: →regions: ______________________________

☐ **Numbness/Tingling/Pins & Needles**:→regions:______________________________

☐ **Head pain that travels/radiates to**: ☐ left side of head ☐ right side of head ☐ both sides of head ☐ front of head ☐ back of head ☐ top of head ☐ neck ☐ other:______________

☐ **Neck pain that travels/radiates to**: ☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand ☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand ☐ other:______________

☐ **Low Back pain that travels/radiates to**: ☐ left buttock ☐ left thigh ☐ left knee ☐ left foot ☐ right buttock ☐ right thigh ☐ right knee ☐ right foot ☐ other:______________

☐ **ANY OTHER SYMPTOMS**:______________________________

______________________________

3) **List any part of your body that struck anything inside your vehicle** (eg: door, window, roof, dashboard, steering wheel, seatbelt harness, air bag, etc.): ______________________________

4) **Were you knocked unconscious**: ☐No ☐Yes→For how long: ____ minutes/hours/days ☐ not sure

5) **Since this injury occurred, are your symptoms**: ☐ getting worse ☐ no change ☐ improving

6) **At the time of impact, was your head**: ☐ facing forward ☐ turned to the left ☐ turned to the right

**7) Where did you go RIGHT AFTER the accident? CHECK ALL THAT APPLY:**

**→☐ HOSPITAL / URGENT CARE OR →☐ DOCTOR'S OFFICE**

**How did you get to the hospital/office:** ☐ Ambulance ☐ Drove yourself ☐ Someone else drove you

**Were you offered transportation via ambulance:** ☐No ☐Yes → Reason why you declined ambulance:

☐ too scared ☐ could not afford it ☐ no health insurance ☐ just wanted to go home

☐ Other:______________________________

**Hospital/Clinic Name:**______________________ **Doctor's name:**______________________

**X-rays/MRI/CT scans taken:** ☐ Head ☐ Neck ☐ Back ☐ None ☐ Other:______________________

**All Diagnoses:**______________________________

**Treatment/Supports received:** □ exam only □ stitches □ bandages □ neck collar □ crutches □ cane
□ Other:______________________________

**All medications prescribed:** □ "Pain killer" □ "Muscle relaxer" □ "Anti-Inflammatory" □ None
□ Other Medications: ______________________________

**Instructed to:** □ Follow-up with primary doctor □ Get physical therapy □ Take prescribed medications
□ Read "Care for concussions" □ Read "Care for sprains-strains" □ Read "Care for auto injury"
□ Other:______________________________

→□ **HOME - If you went home, did you treat yourself:** □No □Yes→ □ice pack □hot shower □rest
□"Over the counter" medications: □Tylenol □Motrin □Aleve □Aspirin □Excedrin
□ Other:______________________________
**How did you get home:** □ Drove yourself □ Someone else drove you

→□ **OTHER LOCATION**→ Details:______________________________

**8) As a result of this incident, have you seen any OTHER Doctor, Health Care Provider or Therapist:**
□ **URGENT CARE / AFTER HOURS CLINIC → Date(s):** ______________________________
□ **DOCTOR / PROVIDER OFFICE → Date(s):** ______________________________
**Clinic name:**______________________________ **Doctor/Provider name:**______________________________
**Area of Specialty/Type of Provider:** □ Medical Doctor □ Primary Care Dr □ Orthopedic surgeon
□ Pain Management Dr □ Chiropractor □ Acupuncturist □ Physical therapist □ Massage therapist
□ Other: ______________________________
**All Diagnoses:**______________________________
**X-rays/MRI/CT scans taken:** □ None □ Head □ Neck □ Back □ Other:______________________________
**Treatment received:** □ Exam only □ Surgery □ Stitches □ Bandages □ Injections
□ Other:______________________________
**All medications prescribed:** □ "pain killer" □ "muscle relaxer" □ "anti-inflammatory" □ none
□ Other Medications: ______________________________
**Instructed to:** □ Follow-up with primary doctor □ Get physical therapy □ Take prescribed medications
□ Rest □ No instructions given □ Other:______________________________

9) **Any other treatment received for this condition:** □ No □Yes→Date(s) of treatment______________
Treatment Details:

______________________________

10) **IF YOU DID NOT SEE A DOCTOR WITHIN THE FIRST FEW WEEKS, DESCRIBE WHY:**
□ no transportation □ no appointment available □ could not afford care □ no pain was noticed
□ work/home schedule conflicts □ required to work to pay rent/bills □ no health insurance
□ I thought pain/symptoms would "go away"
□ Other:______________________________

## F. Current Health Status

**1) What makes your condition worse:** □sitting □standing □walking □bending forward
□lying down on back □ Other: ______________________________

**2) What makes your condition better:** □ ice pack □ hot shower □ rest □ standing □lying on back
□ Medications→______________________________
□ Other: ______________________________

**3) Describe the quality of your pain/condition:** □ sharp □ dull □ achy □ burning □ throbbing
□ Other quality:

**4) What percent of the time do you have your pain / condition (% of day):**
□ constant [100%] □ frequent [75%] □ intermittent [50%] □ occasional [25%]

## G. Your Daily Activities at Home/Work/School

1) **Since this injury, have you lost time from work/school:** ☐ No ☐Yes→List dates missed: ______________________________

Last day worked: ☐ Date of Incident ☐ Other date:______________________________
Current salary: $__________ per hour/week/month/year Tips (Avge per day): $__________
Total amount of lost pay to date: $ __________
Are you being compensated for time lost from work: ☐ No ☐Yes→
If YES, type of compensation you are receiving:______________________________

2) **Are you currently working?**
☐**No** → Are you: ☐ looking for employment ☐ "stay at home" parent ☐ other:__________
☐**Yes** → Are you on: ☐ regular duty ☐ light duty ☐ part time ☐ other:__________
**Are you currently a student?** ☐**Yes** → Are you taking classes: ☐ full time ☐ part time
☐ other:______________________________

3) **Do you notice any activities that are difficult to do at WORK / SCHOOL as a result of this injury?**
☐No ☐Yes → Details: ______________________________

______________________________

4) **Do you notice any activities that are difficult to do at HOME as a result of this injury?**
☐No ☐Yes → Details: ______________________________

______________________________

5) **Since the incident, do you have more difficulty at home with raising children?** ☐N/A ☐No ☐Yes→
# Kids______ → List Ages:______________________________

6) **Do you require assistance from another family member/friend or hired help/nanny?**
☐No ☐Yes→Details: ______________________________

7) **Since the incident, are there any activities that you are now no longer able to enjoy OR have difficulty doing due to incident** (e.g. hobbies, sports, domestic duties, household duties, etc….)?
☐No ☐Yes→Details: ______________________________

## H. Previous Medical History [NOT relating to current injury/incident]

1) Current Age: ______ Height: feet=____ inches=____ Weight: ______pounds
2) Date of Last Medical Exam/Physical: __________ ☐don't recall
Doctor/Office Name: ______________________________
3) Results/Findings/Diagnoses:______________________________

______________________________
4) Results of Blood/Lab Tests: ______________________________
5) Results of X-rays/CT/MRI: ______________________________
6) Other Tests: :______________________________
7) **For Women**: Is there any chance you may be pregnant: ☐ No ☐ Yes→# weeks:
8) **All Prescribed Medications**:______________________________
9) **All Over-The-Counter Medications**: ______________________________
10) **Do you have any congenital (from birth) factors which relate to your condition:**
☐ No ☐ Yes→details/dates: ______________________________
11) **Do you have any previous illnesses/complications from previous injuries:**
☐ No ☐ Yes→details/dates: ______________________________

12) **Have you ever been involved in any accident in the last 10 years:** ☐ No ☐ Yes→details/dates:

___

Treatment Received for previous injuries: ☐ None ☐ Yes→details:___

___

Any residual pain/symptoms/complications from previous injuries: ☐ None ☐ Yes→details:

___

13) **Did you have any physical complaints before this incident**: ☐ No ☐ Yes→___

___

14) **Have you ever been to the hospital for any reason (surgery, trauma, childhood, etc.):**
☐ No ☐ Yes→details/dates:___

**EXCLUDING injuries from this accident, have you EVER had injuries to any of the following regions? Please state RIGHT/LEFT side, details, dates, any complications, healed/resolved:**

| *YES* | *NO* | | *YES* | *NO* | |
|---|---|---|---|---|---|
| ☐ | ☐ | Head ___ | ☐ | ☐ | Hip [R or L] ___ |
| ☐ | ☐ | Neck ___ | ☐ | ☐ | Knee [R or L] ___ |
| ☐ | ☐ | Spine ___ | ☐ | ☐ | Thigh [R or L] ___ |
| ☐ | ☐ | Shoulder [R or L] ___ | ☐ | ☐ | Calf [R or L] ___ |
| ☐ | ☐ | Elbow [R or L] ___ | ☐ | ☐ | Ankle [R or L] ___ |
| ☐ | ☐ | Wrist [R or L] ___ | ☐ | ☐ | Foot [R or L] ___ |
| ☐ | ☐ | Hand [R or L] ___ | ☐ | ☐ | Toes [R or L] ___ |
| ☐ | ☐ | Fingers [R or L] ___ | ☐ | ☐ | OTHER ___ |

___

## I. Previous Medical Concerns [NOT relating to current injury/incident] Check ALL of the following that apply to you.

| *YES* | *NO* | | *YES* | *NO* | |
|---|---|---|---|---|---|
| ☐ | ☐ | Loss of consciousness/head injuries | ☐ | ☐ | Lupus |
| ☐ | ☐ | Seizures/Epilepsy/Convulsions | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Dizziness/Fainting | ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Visual disturbances/Eye problems | ☐ | ☐ | Hernia |
| ☐ | ☐ | Nose, throat, breathing problems | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | Asthma, allergies, allergic reactions | ☐ | ☐ | Sleep apnea/sleep conditions |
| ☐ | ☐ | Diarrhea, constipation | ☐ | ☐ | Menstrual problems |
| ☐ | ☐ | Numbness in groin/buttocks | ☐ | ☐ | Urinary problems |
| ☐ | ☐ | Abnormal/rapid weight gain/loss | ☐ | ☐ | Recent fever |
| ☐ | ☐ | High blood pressure | ☐ | ☐ | Corticosteroid – cortisone, prednisone |
| ☐ | ☐ | Artificial joints | ☐ | ☐ | Birth control pills |
| ☐ | ☐ | Pain at night | ☐ | ☐ | Alcohol/tobacco/drug abuse |
| ☐ | ☐ | Pain unrelieved by position/rest | ☐ | ☐ | Rheumatoid arthritis |
| ☐ | ☐ | Morning pain/stiffness | ☐ | ☐ | Blood disease: ___ |
| ☐ | ☐ | Cancer/tumor/lumps: ___ | | | |
| ☐ | ☐ | Stroke [date/complications]:___ | | | |

Organ Problems/Diseases: ☐Heart ☐Liver ☐Kidney ☐Stomach ☐Pancreas ☐Gall bladder ☐Lungs ☐Intestines ☐Prostate ☐Uterus ☐Ovaries ☐Thyroid ☐Other:___