Automobile/Personal Injury Questionnaire

About this Patient

First Name _____ **Middle Name:** _____ **Last Name** _____

Street Address

_____

City _____ **State/Province** _____ **Zip Code** _____

Cell Phone _____

Gender
☐ Female ☐ Male ☐ Non-Binary

Birthday _____

Employer _____ **Type of Work** _____

Marital Status
◯ Married ◯ Single ◯ Divorced/Separated ◯ Other

Emergency Contact

First Name _____ **Last Name** _____

Relationship _____ **Cell Phone** _____

Information about the Accident / Present Injury

Please explain in detail how your accident happened:

_____

Were you knocked unconscious
☐ Yes ☐ No

You were struck from:
☐ Behind ☐ Front
☐ Left side ☐ Right side

You were:
☐ Driver ☐ Passenger
☐ Back seat - left ☐ Back seat - right
☐ Using seat belts ☐ Airbags Deployed

What direction were you heading:
☐ North ☐ South ☐ East ☐ West

What was the time and date of present injury? _____

Where did you feel pain immediately after the accident?

_____

List the extent of your injuries as you know them:

_____

Did you require post-accident hospitalization?

☐ Yes ☐ No

Where were you taken after the accident?

_____

What treatment was given?

_____

Was any doctor consulted after your accident?

☐ Yes ☐ No

If so, what was the doctor's name?

_____

What was the diagnosis?

_____

What treatment was given?

_____

How frequently did you see the doctor?

_____

How long did you see the doctor?

_____

Have you ever had any complaints in the involved area before?

☐ Yes ☐ No

If so, what were the complaints?

_____

Before the injury were you capable of working on an equal basis with others your age?

☐ Yes ☐ No

Are your work activities restricted as a result of this accident?

☐ Yes ☐ No

Since this injury are your symptoms are:

☐ Improving ☐ Getting worse ☐ Same

Insurance Information

Driver of vehicle in which you were injured (if applicable):

First and Last Name

_____

Insurance Company

_____

Claim No.

_____

Name of your insurance adjustor:

_____

Adjustor Email or Phone #:

_____

Adjustor Fax #:

_____

Have you retained an attorney?

☐ Yes ☐ No

If yes, what is their name?

_____

If so, what is their email or phone #?

_____

Outcome Assessment

Check symptoms you have noticed since the accident:

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

Symptoms other than above:

_____

Using the scale below for reference, please answer the following questions as accurately as possible

What is the pain level of your primary complaint RIGHT NOW? (0-no pain; 10-worst possible pain)

_____

What is the TYPICAL/AVERAGE pain of your primary complaint? (0-no pain; 10-worst possible pain)

_____

What is the pain level of your primary complaint AT ITS BEST? (0-no pain; 10-worst possible pain)

_____

What is the pain level of your primary complaint AT ITS WORST (0-no pain; 10-worst possible pain)?

_____

When did this condition begin?

_____

Overall frequency of complaint (Please check only one)

☐ Constant - 100% of the time ☐ Frequent - 75% ☐ Intermittent - 50% ☐ Occasional - 25%

Is this problem affecting any other area of your body? If yes, please explain:

_____

Does it interfere with your normal daily activities (Family, recreation, sports)?

_____

Do your symptoms increase while performing your normal work duties?

☐ Yes ☐ No

If yes, please select the amount below that you feel your symptoms increase at work:

☐ 0% ☐ 10% ☐ 20% ☐ 30%
☐ 40% ☐ 50% ☐ 60% ☐ 70%
☐ 80% ☐ 90% ☐ 100%

What aggravates the problem?

_____

What relieves the problem?

_____

Has this condition

◯ Gotten worse ◯ Stayed Constant ◯ Comes and goes

Does this condition interfere with

☐ Work ☐ Sleep
☐ Daily Routine ☐ Other activities

Has this condition occurred before?

◯ Yes ◯ No

Explain

_____

Have you seen other doctors for this condition?

◯ No ◯ Yes

Doctor's Name (s)

_____

Type of Treatment

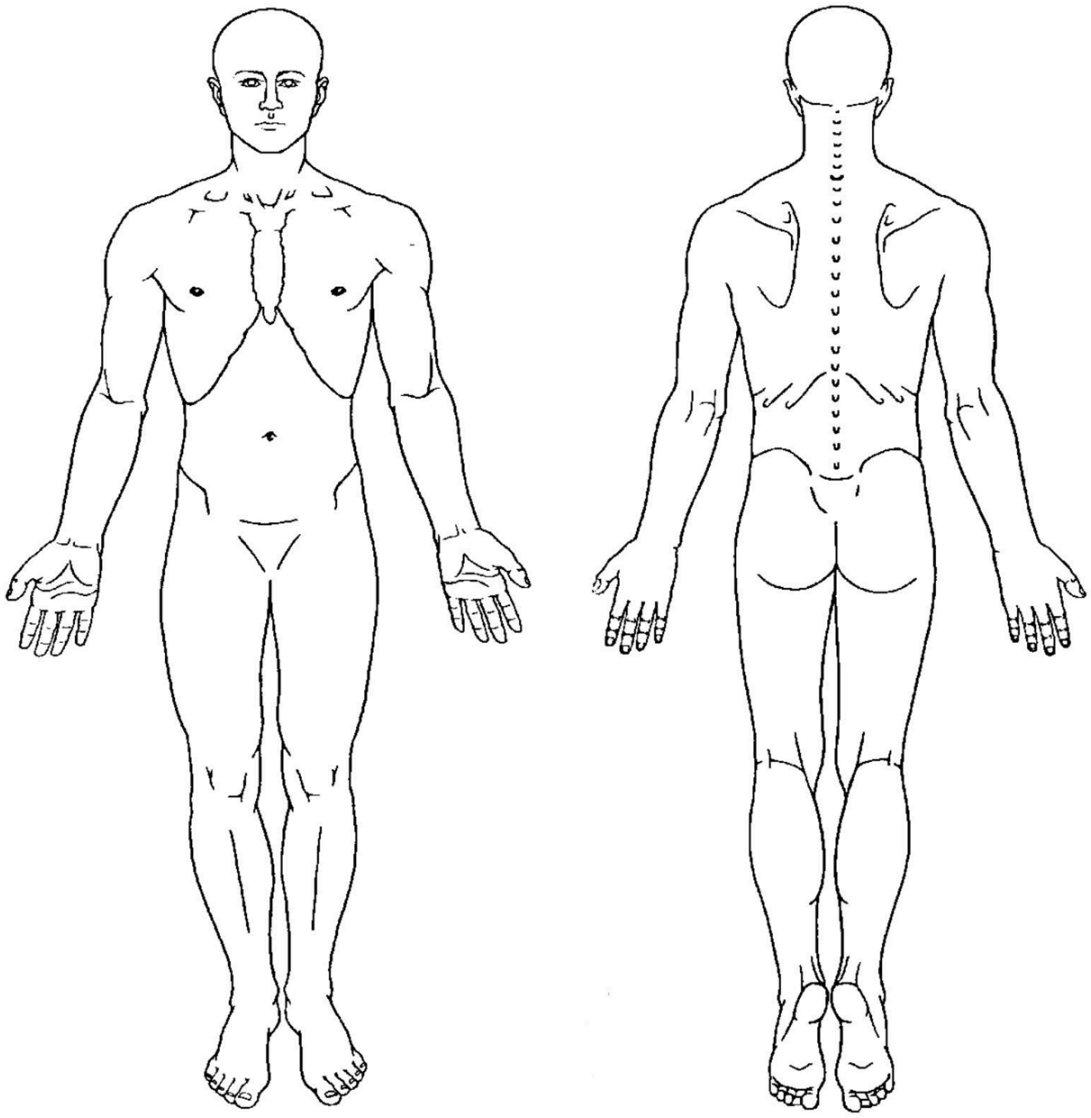
_____

Results

_____

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Please list approximate dates of past car/auto accidents:

Previous Surgeries / Hospitalizations:

Additional Notes:

Experience with Chiropractic

Have you been adjusted by a chiropractor before?

◯ Yes ◯ No

Reason for those visits?

_____

Doctor's Name

_____

Approximate date of last visit?

_____

Medications I Now Take:

- ☐ Nerve Pills
- ☐ Pain Killers (including Aspirins)
- ☐ Muscle Relaxers
- ☐ Blood Pressure Medicine
- ☐ Insulin
- ☐ Stimulants
- ☐ Blood Thinners
- ☐ Tranquilizers

Other medications not listed in the previous section:

_____

Health Habits

Do you smoke or vape?

◯ Yes ◯ No

Do you drink alcohol?

◯ Yes ◯ No

Do you exercise regularly?

◯ Daily ◯ Moderately ◯ No

Do you drink coffee?

◯ Yes ◯ No

Health Systems Review

Please check each of the conditions that you have experienced within the past 6 months.

Health Conditions:

- ☐ Severe or Frequent Headaches
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Pain Between the Shoulders
- ☐ Numbness in Arms/Legs/Hands
- ☐ Digestive Problems
- ☐ Heart Attack/Stroke
- ☐ Kidney Problems
- ☐ Heart Surgery/Pacemaker
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Venereal Disease
- ☐ Diabetes
- ☐ Shingles
- ☐ Anemia
- ☐ Sinus Problems
- ☐ Cancer
- ☐ Hepatitis
- ☐ Frequent Neck Pain
- ☐ Lower Back Problems
- ☐ Ulcers/Colitis
- ☐ Thyroid Problems
- ☐ Congenital Heart Defect
- ☐ High/Low Blood Pressure
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Alcohol/Drug Abuse
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Chemotherapy

Is there any other health condition that you'd like the doctor to know about?

_____

FOR WOMEN ONLY:

Are you pregnant?

◯ Yes ◯ No

Are you nursing?

◯ Yes ◯ No

Under Minnesota no-fault laws, your auto insurance company pays 100% of covered service to your doctor's office if their liability is established.

You are responsible for paying any services not paid by your auto insurance. In the event that your insurance denies liability for your accident, payment for services rendered becomes your responsibility.

I have read, understand, and agree to abide by the information stated above.

Signature

Date Signed

_____

Printed Name

_____

Email

_____

Guardian or Spouse's Signature (if applicable)

_____