Personal Injury Questionnaire

Name_____ Birth Date_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Details of the Accident (please circle appropriate responses):

1. Date of the 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
8. Were you wearing a seat belt atthe time? Yes No

What type of belt? Lap belt Shoulder belt Lap & shoulder belt

9. Describe the position of your head rest or seat back relative to the position of the top of your ears at impact: Above top of ears Below top of ears # inches aboveor below top of ears:_____
10. List the year, make and model of the vehicle you were in:_____
11. Was the vehicle you were in at the time of impact: Stopped or Moving

If stopped, was driver's foor on the brake: Yes No

If moving, estimate approximate speed of the vehicle:_____

12. In your own words, please describe the accident:

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

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

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

17. 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?

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

19. Which of the following vehicle parts broke during the accident: Windshield Rt./Lt. Window Front/Back seat Steering wheel Other_____
20. 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:_____
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? 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 date below:

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

_____

Patient's Signature **Date**

ALLEGHENY ADVANCED CHIROPRACTIC

ACCIDENT INFORMATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

Is this visit related to: [ ] Auto Accident [ ] Worker's Comp. [ ] Personal Injury [ ] Accident

Date of accident: _____ **Time:** _____ **[ ] AM [ ] PM Location of accident:** _____

Describe circumstances of your injury: _____

_____

_____

INSURANCE INFORMATION:

Carrier responsible for bill: _____ Claim No.: _____

Insurance company address: _____

Insurance company: Phone No.: ( ) _____ Fax No.: ( ) _____

Name of insured: _____ Policy No.: _____

Claim adjuster's name: _____ Phone No.: ( ) _____

IF WORK RELATED, COMPLETE THE FOLLOWING:

Company Name: _____ Phone No.: ( ) _____

Company Street Address: _____

City, State, Zip Code: _____

Company Contact Person: _____ Phone No.: ( ) _____

Was the injury reported to your foreman/employer? [ ] Yes [ ] No If yes, by whom: _____

Did he/she/they recommend care at our office? [ ] Yes [ ] No If yes, by whom: _____

Have you lost any days of work? [ ] Yes [ ] No If yes, list dates: _____

IF AUTO ACCIDENT, COMPLETE THE FOLLOWING:

Were you: [ ] Driver [ ] Passenger [ ] Pedestrian Was post-accident hospitalization required? [ ] Yes [ ] No

If auto collision, were you struck from: [ ] Behind [ ] Right side [ ] Left side [ ] Front [ ] Auto parked

Did your car strike the other(s) involved? [ ] Yes [ ] No Did the other car strike yours? [ ] Yes [ ] No [ ] Undetermined

As a result of the accident, were traffic citations issued? [ ] Yes [ ] No

If yes, to whom: [ ] You [ ] Driver of other car [ ] Driver of car in which you were a passenger